

076152 DEC 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

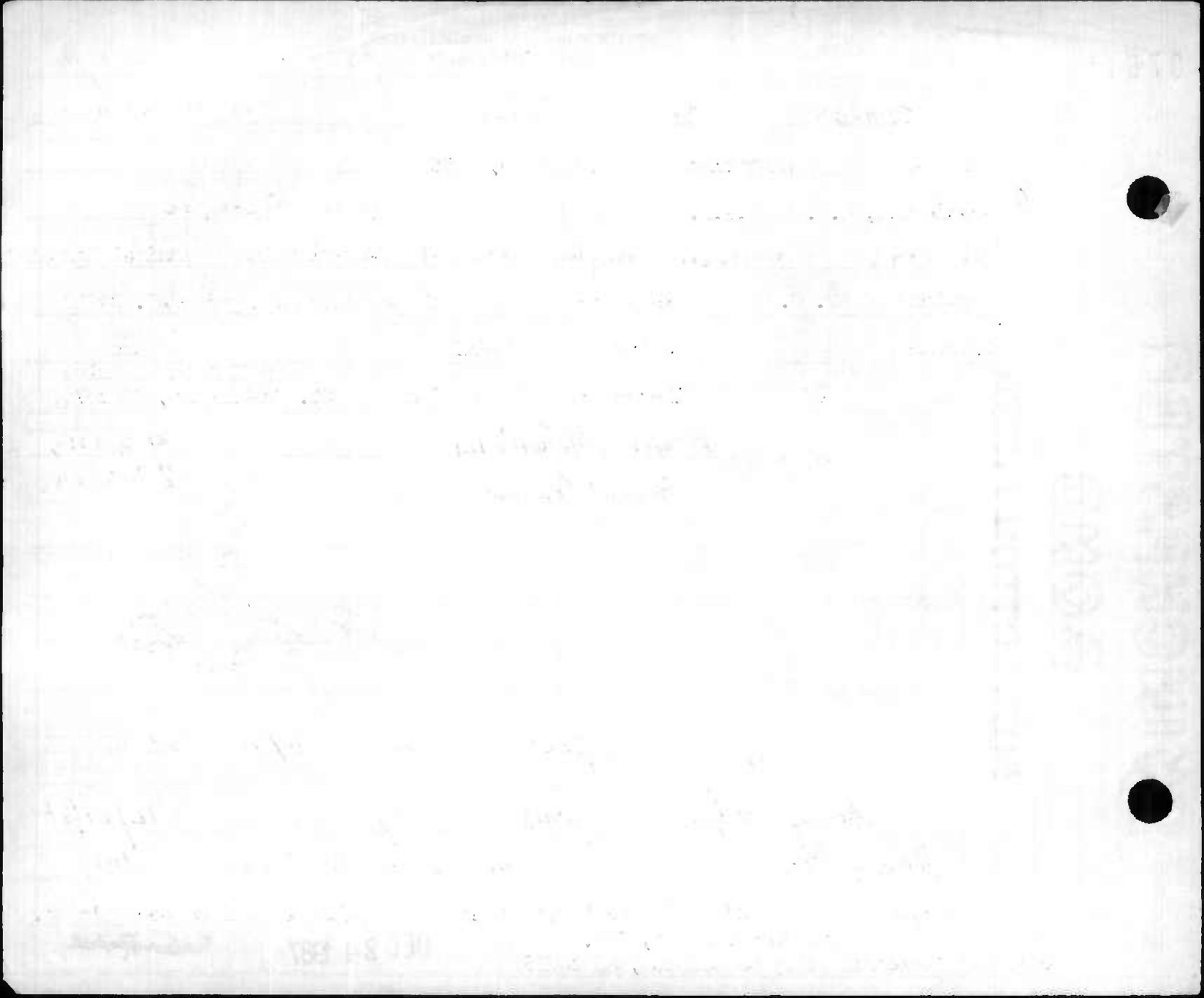
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 5 4 6 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHARON Ann ADLER		2a. DATE OF DEATH MONTH DAY YEAR 12 21 87		2b. HOUR 11 40 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1955	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN Maryland Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Brandywine	
14. FATHER'S NAME FIRST MIDDLE LAST Maurice Adler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shada Myers		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Shada Adler	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months 27 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>87</u> , to <u>12/21</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Harry Kamen</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 12/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARRY KAMEN</u>		22e. ADDRESS <u>5926 Woodley Rd Clinton MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.		23e. DATE REC'D BY REGISTRAR DEC 24 1987			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24c. ADDRESS Old Alexander Ferry Rd Clinton, Md 20735					

BP



076485 DEC 30 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36470

1. DECEASED NAME (TYPE OR PRINT) Henry ALLEN			2a. DATE OF DEATH MONTH DAY YEAR December 5, 1987			2b. HOUR 3:35a.m.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR February 21, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.M.I. Doctors' Hosp. of Pr. Geo.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE Virginia		13b. COUNTY Greensville		13c. CITY OR TOWN Emporia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE HC 1, Box 887 23847	
14. FATHER'S NAME FIRST MIDDLE LAST William Allen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Indiana Jenkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 718-09-5064		17. INFORMANT ADDRESS Mrs. Mary Allen HC 1, Box 887 Emporia, VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastro intestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis, military</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 8118 Good Luck Rd		CITY OR TOWN LANHAM, MD			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Jerry B. Harmon, MD		DEGREE Pathologist		22c. DATE SIGNED 12-6-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerry B. Harmon		22e. ADDRESS Docs Hosp P.E. Co		22f. ADDRESS 8118 Good Luck Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-10-87		23c. NAME OF CEMETERY OR CREMATORY Diamond Grove Cemtery		23d. LOCATION CITY OR TOWN Skippers, Greensville VA			
24. FUNERAL DIRECTOR NAME BOND FUNERAL SERVICE		ADDRESS 556 Halifax St. Emporia,		25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE John R. Rucker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove contents of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VIA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON, BALTIMORE, MARYLAND 21201

100-100-100

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100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

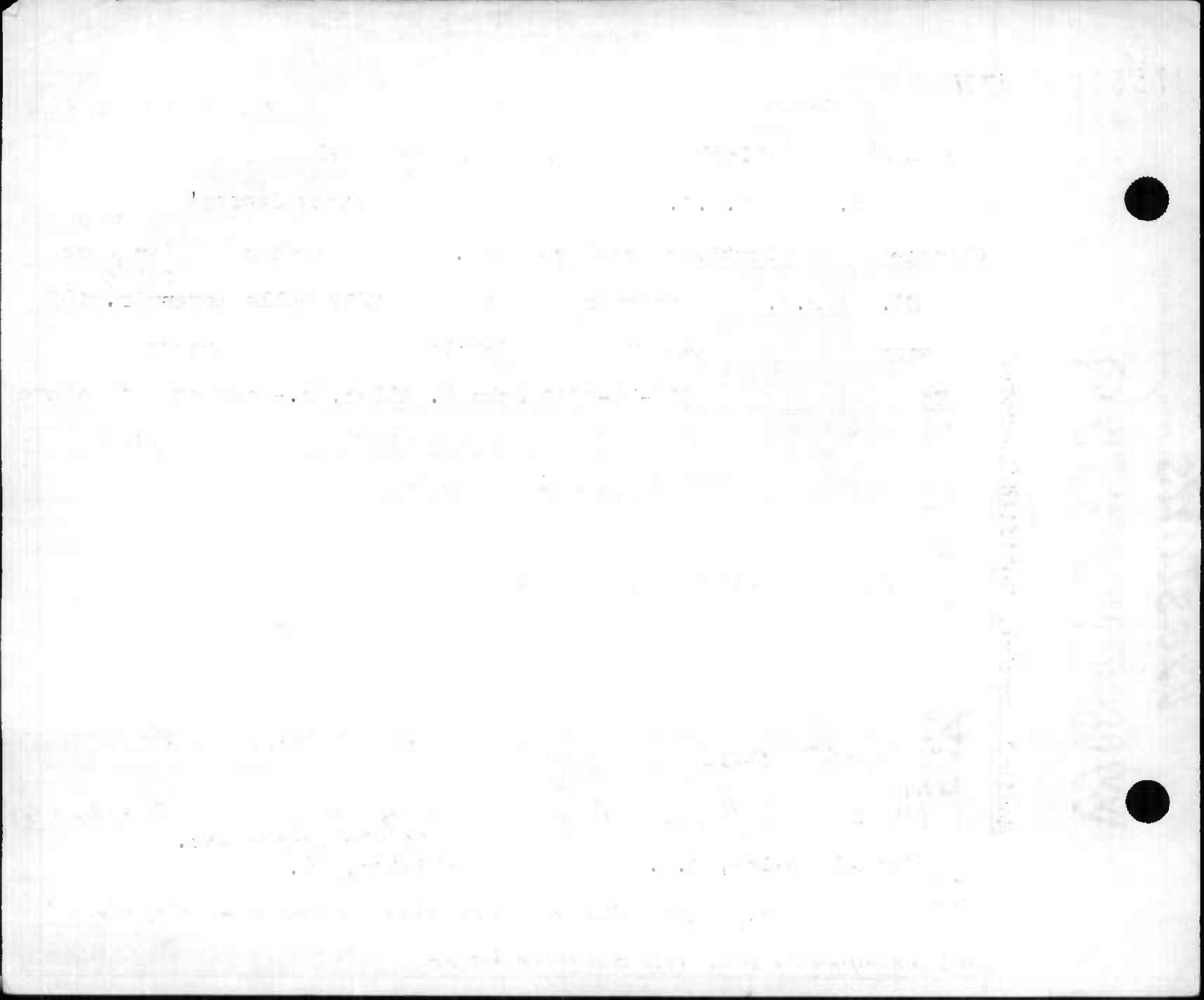
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified or called.

Medical Examiner Notified/Approved

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		3. SEX			
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		DATE OF DEATH	
Mary		Allen		12-10-87		2130		Female	
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?	
Black		2-11-97		90		Md.		U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Prince Georges		Clinton		Southern Maryland Hosp.		Homemaker		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		P.G.		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1827 Belle Haven Dr. #103 20785	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Henry		Hattie		No		577-84-3521		John E. Allen, Jr. - Same as # 13 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
CORONARY ARREST						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF									
POSSIBLE CVA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) (c)									
Previous CVA, mild stroke									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		12/10/87							
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
I saw the deceased alive on 12/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		Michael Levine MD		DECEMBER 11, 1987		Michael Levine, M.D.		7801 Old Branch Ave. Clinton, Md.	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
		12/15/87		HARMONY MEM. PARK		LANDOVER, P.G., MD.		DEC 16 1987	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
H.S. WASHINGTON & SONS 4925 BURKHOUGH AVE. N.E.		DEC 16 1987		John Davidson-Randall					



072991 NOV 25 87

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

6 4 7 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Leroy						Anderson Sr.		ESTIMATED		11/		17		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	05/30/30		57 YRS.						11/		19		87		10:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Florida		U.S.A.		WIDOWED		DIVORCED		Prince George's County								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Upper Marlboro		10910 Holloway Dr.		Gvt. Employee-Ret		U.S. Gov't.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Prince George's		Upper Marlboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10910 Holloway Drive								20772	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Henry		Louise															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		Korean		251-30-8747		Ethel Anderson/13607 Cole Fair Dr.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		Assistant		11/20/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		11/24/87		Allen Chapel Ch. Cem		St. Stephens S.C.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
John T. Rhines Fun. Hm.		Washington, D.C.		NOV 24 1987		Dennis F. Smyth											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25AM

BP

DHMH - 17
(VR A15 ME (5))

WES 4001 10 05 70

077243 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8730473

1. DECEASED NAME (TYPE OR PRINT) PHILLIP John ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 12 28 87		2b. HOUR 12 25A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 15 13	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier	12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Service	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6604 Parkwood Street 20784
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Lohman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-10-7274	17. INFORMANT ADDRESS 6604 Parkwood St. Audrey Anderson (Wife) Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DIABETES MELLITUS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>GANGRENE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>64</u> to <u>PRESENT</u> 19 <u>87</u> , that (I) (some) last saw the deceased alive on <u>DEC 27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Don Blouin</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>12-28-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DON B. CAMERON, MD.</u>				22e. ADDRESS <u>2005 LANDOVER RD CHEVERLY, MD 20785</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/31/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	23e. DATE REC'D. BY REGISTRAR JAN 5 1988
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781					
25a. DATE REC'D. BY REGISTRAR JAN 5 1988					

REGISTRAR'S SIGNATURE
John E. Anderson

1-513570

RECEIVED JAN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

JAN 5 1964

075248 DEC 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36474

1. DECEASED NAME (TYPE OR PRINT) James A. Arneson			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1987		2b. HOUR 3:20 A.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 24, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH prince George's MD.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exterminator Ret.		12b. KIND OF BUSINESS OR INDUSTRY Pest Control		
13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Arneson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel G. Carrico					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-05-8463		17. INFORMANT ADDRESS 8901 Lemocks Dr. Upper Marlboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Cholesterol - 270 mg/dl - HDL - 60 mg/dl</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/21/87 to 12/12/87 that (I) (we) last saw the deceased alive on 12/11/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.								
22b. SIGNATURE <u>Robert M. ...</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REZA MOSTAFAN				22e. ADDRESS 4235 26th Ave NW 20745				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR DEC 15 1987		
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove contents of page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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DEC 12 1930

107 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REGNO

6475

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Rose</i>			MIDDLE <i>Marie</i>			LAST <i>Audet</i>			2a. DATE KNOWN OF DEATH			KNOWN ESTI. MATED <input checked="" type="checkbox"/>			MONTH <i>12</i>			DAY <i>10</i>			YEAR <i>19 87</i>			2b. HOUR A. <i>6:45</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>Feb.</i> DAY <i>14,</i> YEAR <i>1928</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS.		IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>		2c. DATE PRONOUNCED DEAD <i>12/10 19 87</i>			MONTH <i>12</i>			DAY <i>10</i>			YEAR <i>19 87</i>			2d. HOUR A. <i>6:45</i>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Rhode Island</i>				7b. CITIZEN OF WHAT COUNTRY? <i>US</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's County</i> MD																			
10. CITY OR TOWN OF DEATH <i>Laurel</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>13912 Saratoga Avenue</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>REST.</i>															
USUAL RESIDENCE (IF IN HOSPITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																															
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Prince George's</i>				13c. CITY OR TOWN <i>Laurel</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>13912 Saratoga Avenue</i>															
14. FATHER'S NAME FIRST <i>Thomas</i>								MIDDLE <i>DiSalvo</i>								LAST <i>May</i>															
15. MOTHER'S MAIDEN NAME FIRST <i>May</i>								MIDDLE <i>Callahan</i>								LAST <i>Callahan</i>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>n/a</i>								16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>n/a</i>								17. INFORMANT <i>Arthur J. Audet</i>								ADDRESS <i>same as 13e</i>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>	(b) _____ DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____ DUE TO, OR AS A CONSEQUENCE OF	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |a

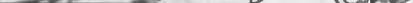
NONE	None
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None
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MEDICAL HISTORY	21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE  TITLE (SPECIFY) Deputy DATE SIGNED 12/11/87
M.D. MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road
Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/14/87	23c. NAME OF CEMETERY OR CREMATORY Md.Vet's Cemetery	23d. LOCATION CITY OR TOWN Crownsville COUNTY A.A. STATE Md.
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74 FUNERAL DIRECTOR	7601 Sandy Spr.Rd.	75a. DATE REC'D. BY REGISTRAR	75b. REGISTRAR'S SIGNATURE
NAME	ADDRESS	DEC 14 1987	Robert Davidson-Randall
Fleck Funeral Home, Inc. Laurel, Md. 20707			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 12, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF PUBLIC RECORDS, 20 N. B'CON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP_____

DHMH - 17

(VR A15 ME (5))

DHMH - 17
/R A15 ME (5))

7 DEC 14 1987

RECEIVED

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100-111111

075480 DEC 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 66476

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Mary Frances Ayers						<input checked="" type="checkbox"/> ESTI. MATED			12-13 1987			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		White		July 31, 1907		80		MONTHS DAYS		HOURS MIN		12-13 1987		11:55 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U.S.A.								Prince George's County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale				Leland Memorial Hospital				Restaurant Owner				Self Employed			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Westmoreland				Oak Grove				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS				15. MOTHER'S MAIDEN NAME				17. INFORMANT (Daughter)				341 N.E. 50th Court			
Route 1 Box 1 99999				Cora				Marcell McCully				Ocala, Florida 32671			
4. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				17. INFORMANT (Daughter)				341 N.E. 50th Court			
Benjamin				Cora				Marcell McCully				Ocala, Florida 32671			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (Daughter)				341 N.E. 50th Court			
No				579-01-2036				Marcell McCully				Ocala, Florida 32671			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Head Injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-10 1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell down stairs

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home
21f. LOCATION CITY OR TOWN COUNTY STATE 5801 42nd Ave., Hyattsville, Prince George's Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle, Jr., M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-14-87

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE	
Burial		12/16/87		Oak Grove Cemetery		Colonial Beach Westmoreland Va	
24. FUNERAL DIRECTOR OR ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Maryland 20782				DEC 17 1987 <u>John Seiden</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP

FORM 17
(VR A15 ME (5))

100-100-100

20% COTTON FIBER

UNITED STATES
MAR 1941



100-100-100

075850 DEC 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6477

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

First MIDDLE LAST
Dorothy M. Bailey

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12-15-87

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH
MONTH DAY YEAR
3-16-02

6. AGE (IN YEARS)
(LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
85 YRS.

7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-15-87

2b. HOUR
24 HOUR
1007

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington DC

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

10. CITY OR TOWN OF DEATH

Suitland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)

3408 Glenn Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

PR GEORGE

13c. CITY OR TOWN

Suitland

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

3408 Glenn Drive 20746

14. FATHER'S NAME

First MIDDLE LAST
Thomas Chesterfield Fox

15. MOTHER'S MAIDEN NAME

First MIDDLE LAST
Catherine Irene Donaldson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

579-24-1563

17. INFORMANT

Margaret Bailey

ADDRESS

Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinomatous, abdomen

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetic arterial atherosclerotic cardiovascular disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusta P. Rodriguez

TITLE (SPECIFY)
Deputy

MEDICAL EXAMINER

DATE SIGNED

12-15-87

EXAMINER'S NAME
(TYPE OR PRINT)

Augusta P. Rodriguez MD

ADDRESS

5009 Rappahannock Ch. Cr. Sp. Pr. Ges. Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

17 Dec 1987

23c. NAME OF CEMETERY OR CREMATORY

Glenwood Cemetery

23d. LOCATION (CITY OR TOWN)

Washington DC

COUNTY STATE

24. FUNERAL DIRECTOR NAME

Robert E Wilhelm

Funeral Home

Suitland, Md.

25a. DATE REC'D. BY REGISTRAR

DEC 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Dandrea-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



WINTER

20% COTTON

WINTER
20% COTTON

WINTER

20% COTTON

WINTER

20% COTTON

WINTER

20% COTTON

075889 DEC 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 38478

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL W Bailey			2a. DATE OF DEATH MONTH DAY YEAR 12-8-87		2b. HOUR 5:50 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1911		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 76		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
13a. STATE MD.		13b. COUNTY Prince Geo		13c. CITY OR TOWN Forestville		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Wood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hager		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Gloria Fisher Forestville, MD 20747		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (c) Dehydration						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/8/87 to 12/8/87 that (I) (we) lost saw the deceased alive on 12/8/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE L. BERWEN		DEGREE MD		22c. DATE SIGNED 12.9.87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BERWEN		22e. ADDRESS 10658 CAMPUS WAY SOUTH UPPER MARLBORO				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem.		
24. FUNERAL DIRECTOR NAME Stewart		23d. LOCATION CITY OR TOWN COUNTY STATE Landover MD		25a. DATE REC'D BY REGISTRAR DEC 22 1987		
25b. REGISTRAR'S SIGNATURE John T. Stewart III		25c. REGISTRAR'S SIGNATURE John T. Stewart III				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07280 10/11/71

CONFIDENTIAL

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

[Illegible text follows]

DEC 23 1971

077097 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 3647.9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE H. BAIRD			2a. DATE OF DEATH MONTH DAY YEAR 12 29 87		2b. HOUR 12:05 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 21 07		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS 80		
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH P.C. COUNTY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE DC		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WASHINGTON		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4422 HARRISON ST. WASH 20015				
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH HINES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGET DEVINE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 210-03-0334		17. INFORMANT ADDRESS JOHN R. BAIRD (SON) 3004 OLIVER ST. NW WASH D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia 1 wk DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) generalized arteriosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (l) (the hospital) attended the deceased from Dec 15 '87 to Dec 29 1987 , that (we) last saw the deceased alive on Dec 28 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.						
22b. SIGNATURE James J. Foster DEGREE				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Foster				22e. ADDRESS 916 19th N.W. WASH D.C.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 31 '87		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MD						
24. FUNERAL DIRECTOR NAME John F. DeVoi		25a. DATE REC'D BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE		
25c. FUNERAL HOME DEVOL FUNERAL HOME		25d. ADDRESS WASH. D.C.				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

[Faint, illegible handwritten notes]

074675 DEC 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6430

FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Jesse			MIDDLE Allen			LAST Baker			2a. DATE KNOWN OF DEATH ESTI MATED Dec 7 1987			2b. HOUR 8 AM																																																					
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR Oct 9 1927			6. AGE (IN YEARS) (LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD Dec 7 1987			2d. HOUR 8 AM																																																		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.																																																					
10. CITY OR TOWN OF DEATH Riverdale						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Island Mem Hosp						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance						12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.																																																					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE Md												13b. COUNTY Prince Georges												13c. CITY OR TOWN Riverdale												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET ADDRESS 5006 Nicholson Street 20737											
14. FATHER'S NAME FIRST MIDDLE LAST James						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jones						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 577-18-0027						17. INFORMANT (Wife) Beulah M. Baker						5006 Nicholson Street Riverdale, Md. 20737																																									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																																																																							
19a. DATE OF OPERATION <u>None</u>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																																																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																																																							
ACTUAL SIGNATURE <u>John S. Rogers</u>						TITLE (SPECIFY) M.D. <u>Dep</u>						MEDICAL EXAMINER DATE SIGNED <u>Dec 7, 1987</u>																																																											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.						ADDRESS 1919 SEminary Rd. Silver Spring, Md.																																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 12/09/87						23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland																																																					
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781												25. CERTIFIED BY REGISTRAR DEC 9 1987						26. REGISTRAR'S SIGNATURE <u>John Darden</u>																																																					

1971 DEC 13

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074895 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 35401

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND MILLARD BAKER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1987		2b. HOUR 8:27pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 11, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF MedCen		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Sgt.	12b. KIND OF BUSINESS OR INDUSTRY U.S. Army
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.		13c. CITY OR TOWN St. Mary's California	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 32/20619	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond C. Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Diana Ogden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES Yes-Army		16b. SOCIAL SECURITY NO. 579-38-1239		17. INFORMANT Per. Rep. 153 East Main Sen. Walter M. Baker/Elkton, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CANCER OF THE LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 21921 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 17 NOV , 19 87 , to 03 DEC , 19 87 , that (2) we last saw the deceased alive on 03 DEC , 19 87 , and that in my opinion death occurred on the date and hour and from the causes stated above (3) we did not view the body after death.					
22b. SIGNATURE <i>Jefferson H. Harmon</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 03 DEC 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFERSON H. HARMON, CPT, USAF, MC		22e. ADDRESS MALCOLM GROW USAF MEDCEN AAFB, MD 20331			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/07/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtwn, MD.		25. DATE REC'D. BY REGISTRAR DEC 11 1987	
				26. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rubio</i>	

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076722 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

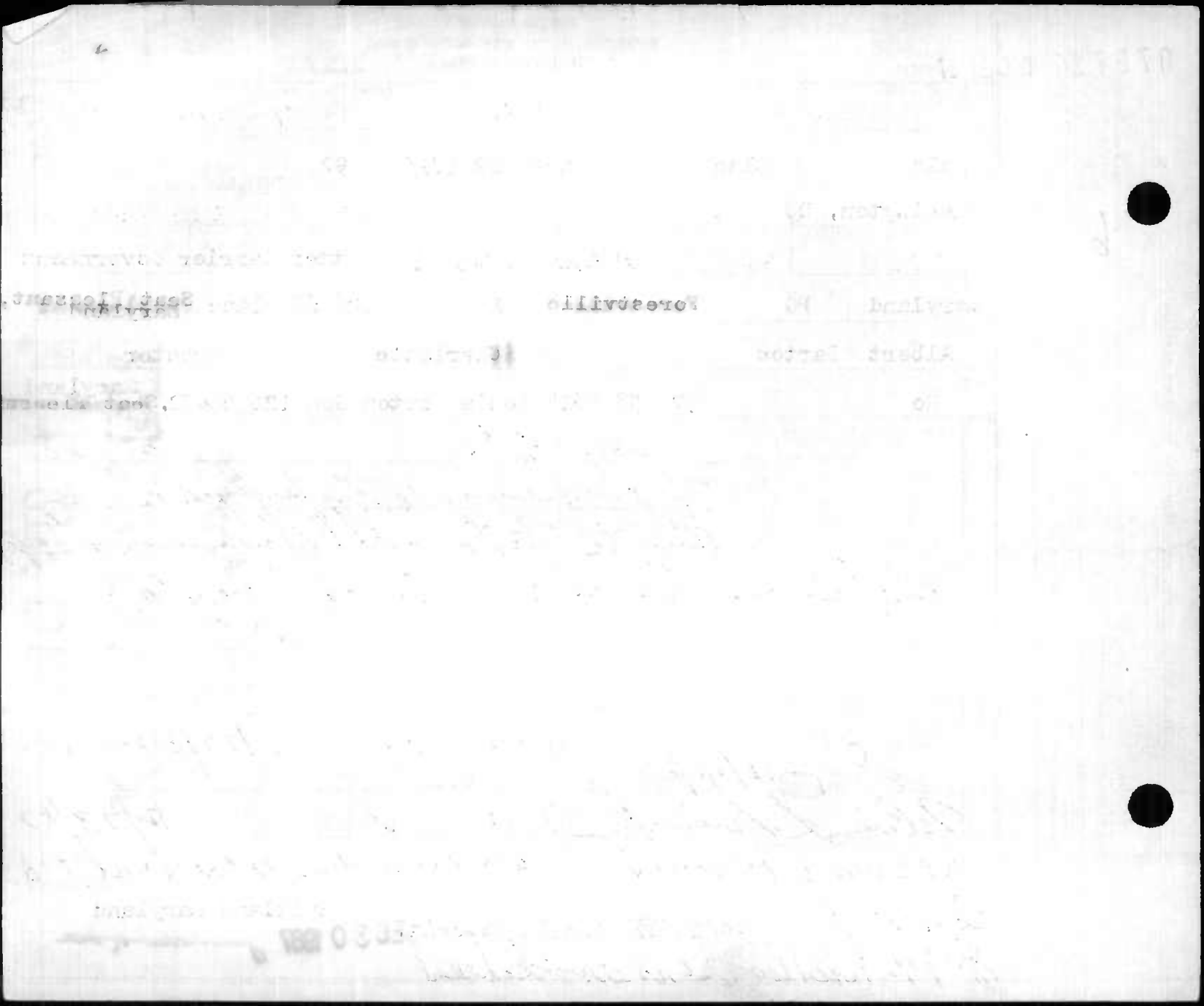
8 7 3 0 4 0 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALBERT BARTON			2a. DATE OF DEATH MONTH DAY YEAR DEC 22, 1987		2b. HOUR MIN 6:15 P
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 22 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier Government	
13a. STATE Maryland		13b. COUNTY PG	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Barton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Proctor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 58 0624		17. INFORMANT ADDRESS Louis Barton Son 126 68 Pl. Seat Pleasant Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asystole DUE TO OR AS A CONSEQUENCE OF: (b) Hypercholesterolemia & Hyperglycemia 1 day (c) Acute B/L Lower Lobe Pneumonia 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alzheimer Disease, Ca of Prostate					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from 11/11 1987 to 12/22/87 that (1) last saw the deceased alive on 12/22/87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) did not know the body after death.					
22a. SIGNATURE Kelvin L. Minchin MD		DEGREE MD		22b. DATE SIGNED 12/23/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) KELVIN L. MINCHIN		22d. ADDRESS 6188 OXON HILL RD OXON HILL MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec/26/87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
23d. LOCATION Suitland Maryland		23e. STATE MD			
24. FUNERAL DIRECTOR E. M. Bulley & Sons		25. ADDRESS 3200 Rte 1			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



18810 01001

18810 01001

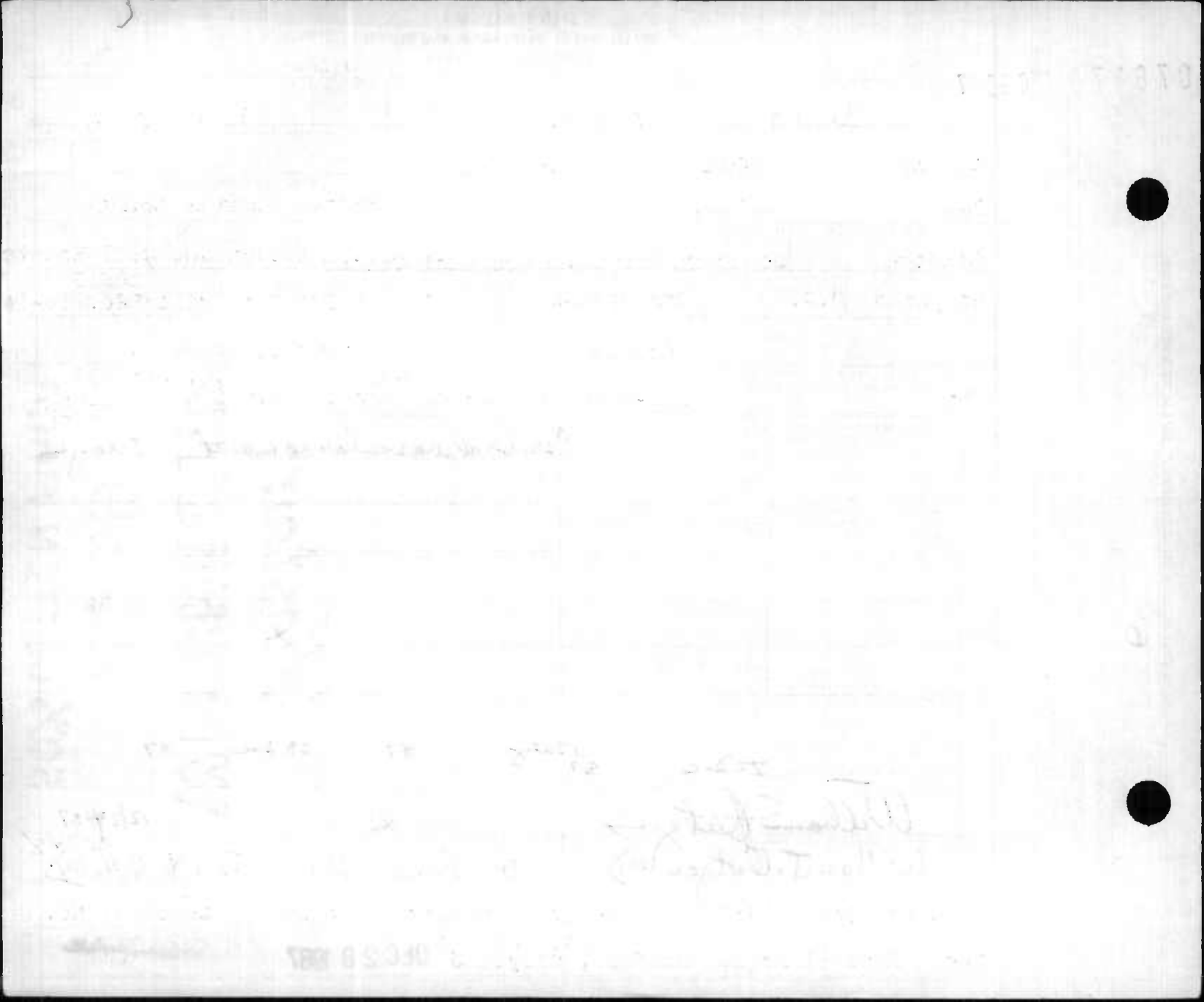
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH MONTH DAY YEAR		2c. HOUR	
		Marian Rebald Bennett				12-23-87		8:15pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. UNDER 1 YEAR MONTHS DAYS	
female		white		10-29-29		58			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pa.		U.S.A.				Prince Georges County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital Center				Accountant		Real Estate	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
Maryland		P.G.		Brandywine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10505 Cedarville Rd. 10-14	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Rebald		Unavailable							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son) ADDRESS					
No		N/A		166-24-4558 Lynn M. Bennett, Lincoln, Montana					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1 July</u> , 19 <u>87</u> , to <u>23 Dec</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>22 Dec</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
William J. Detgen								12/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. DATE REC'D. BY REGISTRAR			
William J. Detgen		3611 Branch Ave Temple Hills, MD				DEC 28 1987			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		12/24/87		Huntt Crematory		Waldorf, Charles, Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Huntt Funeral Home		P.O. Box 156 Waldorf, Maryland		DEC 28 1987		John Davidson			

BP



076467 DEC 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81 REG. NO 36485

1. DECEASED NAME (TYPE OR PRINT) BESSIE M. BERGER			2a. DATE OF DEATH MONTH DAY YEAR 12 22 87		2b. HOUR 9:40 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 21, 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Supervisor		12b. KIND OF BUSINESS OR INDUSTRY AAA Insurance
13a. STATE Maryland	13b. COUNTY Pr George	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 3739 Donnell Drive 20747	
14. FATHER'S NAME FIRST MIDDLE LAST William Blankenship		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Collie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-07-8848		17. INFORMANT ADDITIONAL ADDRESS Ellis Henderson 9211 Shotgun Ct Springfield, Ky.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Hemiparesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Congestive Heart Failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/22/87 to 12/23/87, that (I) (we) lost saw the deceased alive on 12/22/87; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (and) not view the body after death.					
22b. SIGNATURE Supervisor		DEGREE M.D.		22c. DATE SIGNED 12/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WATKINS		22e. ADDRESS WADSWORTH MD 20761			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26Dec1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS Suitland, Md.			
25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE John Henderson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

076228 DEC 28 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6436									
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR							
DECEASED NAME (TYPE OR PRINT) William Carl Bergstrom										MONTH DAY YEAR 12/ 8/ 1987		M 1:03 P M							
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 05-18-05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 12/17/ 1987		2d. HOUR 1:03 P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.							
10. CITY OR TOWN OF DEATH Bladensburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Staffords Marina				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4901 56th Ave., 20710	
14. FATHER'S NAME FIRST MIDDLE LAST John V. Bergstrom				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hedwit Ingeborg															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) yes WW-2				16b. SOCIAL SECURITY NO. 216-44-9289				17. INFORMANT Grace M. Bergstrom, Same as line #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7908 Drowning IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arterioscleotic Cardiovascular Disease																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/ 8/ 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject drowned											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Anacostia River, Prince George's Co., Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12/18/87											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-21-87				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland							
FUNERAL DIRECTOR'S NAME ADDRESS FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland										23e. DATE REC'D. BY REGISTRAR DEC 24 1987		23f. REGISTRAR'S SIGNATURE <i>Anita Fawcett-Badale</i>							



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36487

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERVIN BLACKLEDGE			2a. DATE OF DEATH MONTH DAY YEAR 12 09 87		2b. HOUR 4 10A M						
3. SEX M Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 01 21 47		6. AGE (IN YEARS, LAST BIRTHDAY) 40 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? D.C. United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Private			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY Washington 13c. CITY OR TOWN Washington 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						13e. STREET ADDRESS / ZIP CODE 2125 4th Street, N.W. 99999					
14. FATHER'S NAME FIRST MIDDLE LAST Ervin Blackledge Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Not Stated		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-62-7374		17. INFORMANT ADDRESS Alice V Blackledge Wife				Same as 9D.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardioresp. arrest Sec. to Cryptococcal Meningitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AIDS, cryptococcal meningitis DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/20/87 , 19 87 , to 12/09/87 , 19 87 , that (I) (we) lost saw the deceased alive on 12/09/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE hpsngh				DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/09/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVINDER PAUL SINGH				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Dec. 87		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'L Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland					
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home				ADDRESS 389 Rhode Island		25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE John D. ...			

MEDICAL CERTIFICATION

99999

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: This day requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

NO. 1000000000

1000000000

075993 DEC 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36488

1. DECEASED NAME (TYPE OR PRINT) Ethel R. Blankenbaker			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1987		2b. HOUR 5:15^{PM}
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 19 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD	
10. CITY OR TOWN OF DEATH District Hts	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6100 Cabot Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Pr George	13c. CITY OR TOWN District Hts	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James E Greet			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Nicholson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-18-4292		17. INFORMANT ADDRESS Fern Ellen Terrett Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Smoking					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1-13-87 to 1-17-87 , that (2) (we) last saw the deceased alive on 1-13-87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Edgercombe M.D.				22c. DATE SIGNED 12/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Edgercombe				22e. ADDRESS 7700 Old Branch Ave. Clinton Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 Dec 1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Suitland Md		25. DATE REC'D BY REGISTRAR DEC 22 1987	

MEDICAL CERTIFICATION

47

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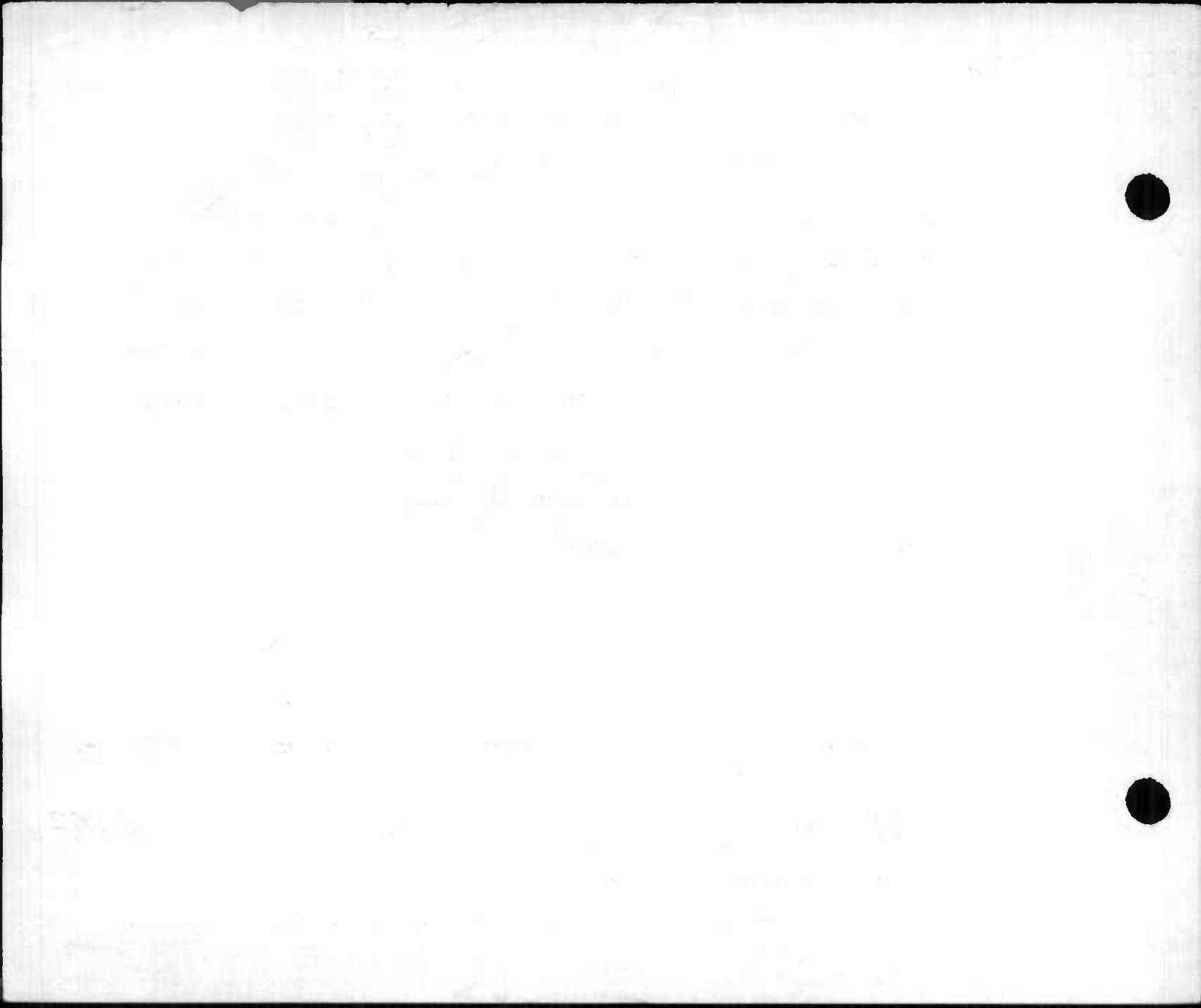
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



76066 DEC 24

FOR Film 6637 item 18,22a

1- STATE REGISTRAR 3-7-88 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 6 4 8 9

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

JAMES

I.

BODDIE

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12 12 1987
2b. HOUR
M
9:08 P M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 12 1987
2d. HOUR
M

Male

Blk

7 18 56

31 YRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Washington, DC U.S.A.

Prince George's County MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Camp Spring

Malcolm Grow Medical Center

Laborer

Pvt.

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

MD.

PG

District Ht

YES ☒ NO ☐20747 Maryland
1315 Karen Blvd/District HT

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Cleveland

Boddie

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Cora

Mae

Dunn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

NO

N/A

578780565

Cora Mae Boddie/1315 Karen Blvd#202

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Narcotic Intoxication

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATHHOUR A.M. MONTH DAY YEAR
P.M. 12-12 1987

Subject used drugs

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

WHILE ☒ NOT WHILE ☐
AT WORK AT WORK

Building

1315 Karen Blvd. Capitol Heights P.G. Md.

22a. I certify that I took charge of the remains described above, held an
death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒
Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinionACTUAL
SIGNATURE

M.D.

TITLE (SPECIFY)

Deputy Chief

MEDICAL EXAMINER

DATE
SIGNED

12-13-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

Burial

12/18/87

Harmony Memorial PK Landover

PG

MD

24. FUNERAL DIRECTOR

24a. NAME

24b. ADDRESS

24c. DATE RECEIVED BY REGISTRAR

24d. REGISTRAR'S SIGNATURE

J. B. Jenkins

Landover, Md. 20785

DEC 23 1987

Julia Borden-Landover

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84
25AADHMH - 17
(VR A15 ME (1))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

8 7 REG. NO 3 6 4 9 0

1. DECEASED NAME (TYPE OR PRINT) JULIA M. BOHN			2a. DATE OF DEATH MONTH DAY YEAR 12 30 87		2b. HOUR 9:55 M						
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 5 15 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Commercial Artist		12b. KIND OF BUSINESS OR INDUSTRY Art			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1700 Westlake Drive			
14. FATHER'S NAME FIRST MIDDLE LAST William Donovan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Hanesko							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 051-16-0628		17. INFORMANT ADDRESS Michael F. Bohn, 2702 Woodcourt Rd., Balt., Md.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **ACUTE CEREBRAL INFARCTION**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
48 HOURS

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPERTENSIVE ATHEROSCLEROTIC CARDIORENAL**

DUE TO, OR AS A CONSEQUENCE OF

VASCULAR DISEASE

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

RENAL FAILURE DIABETES MELLITUS

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6/27/87 to 12/30/87 , that (I) (we) last saw the deceased alive on 12/30/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Marta Anne Schneider MD				DEGREE MD		22c. DATE SIGNED 12/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTA ANNE SCHNEIDER MD				22e. ADDRESS 5401 MACARTHUR BLVD N.W. WASH DC 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/31/87		23c. NAME OF CEMETERY OR CREMATORY Northern Va. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Murphy Funeral Homes, Arlington, Va.				25a. DATE REC'D. BY REGISTRAR JAN 6 1988		25b. REGISTRAR'S SIGNATURE John Davidson Fordale	

1525

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36491

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EKKEN Louise BOWERSOX			2a. DATE OF DEATH MONTH DAY YEAR 12 22 87		2b. HOUR 11-15 PM						
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 30, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Cashier		12b. KIND OF BUSINESS OR INDUSTRY Garfinkles					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY --		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4018 South Capitol SE 20032			

14. FATHER'S NAME FIRST MIDDLE LAST Phillip Bowersox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Lee	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 578-05-8075	
17. INFORMANT Raymond Neill		ADDRESS 9518 Oak Leaf Pl Clinton, Md 20735	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death Defurred Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Pump Failure with Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular Arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Respiratory Distress</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/15, 19 87, to 12/22, 19 87, that (we) lost saw the deceased alive on above, (I/we) (did/did not) view the body after death, and that in (my/our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <u>Lee W. WATKINS</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEE WATKINS				22e. ADDRESS WALDORE MD 20601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George's MD	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc- ADDRESS Old Alexander Ferry Rd Clinton, Md 20735							

074447 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the pathologist's report must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
MARY NORMA BOYLAN					DECEMBER 1 1987					6:40p M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JUNE 3 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY D.C. PUBLIC SCHOOLS			
13a. STATE MARYLAND		13b. COUNTY PR GEORGES		13c. CITY OR TOWN W. HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7333 NEW HAMPSHIRE AVE #411 20783			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BOYLAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELENA SCHEUCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-44-8600		17. INFORMANT COUSIN DORA M. CLARK		ADDRESS 2208 BEECHWOOD RD. HYATTSVILLE, MD 20783					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY HEART DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 WEEKS</u> <u>1 YEAR</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION <u>NOV. 23, 1987</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OCCLUSION RIGHT PULMONARY</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>JAN 1</u> , 19 <u>87</u> , to <u>DEC 1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>DEC 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Samuel N. Sugar</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 2, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL N. SUGAR				22e. ADDRESS 4637 EASTERN AVE. MT. RAINIER, MD 20712							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 4, 1987		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a. DATE REC'D. BY REGISTRAR DEC - 7 1987							
25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>											

BP

17117-031

STATE OF TEXAS

10% COLLEGE

10

DEC 7 1981

077508 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPACE IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36493

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lueada Bradshaw										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-21 19 87		2b. HOUR M 11:04 p.m.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR August 1, 1953		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 34		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-21 19 87		2d. HOUR M 11:04 p.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Private			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY N 13c. CITY OR TOWN Washington										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1780 Lyman Place, N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Willie J. Washington				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Gay				17. INFORMANT ADDRESS Same as 13e.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 417-76-2630				17. INFORMANT ADDRESS Raymond Bradshaw Husband							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10:20 PM 12-21 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/bus impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parkway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto.-Wash. Pkwy., Cheverly, Prince George's Co., Md.							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 12-22-87							
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 29 Dec. 87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland					
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home				ADDRESS 389 R.I. Avenue, N.W. Wash. D.C.				25a. DATE REC'D. BY REGISTRAR JAN 6 1988				25b. REGISTRAR'S SIGNATURE <i>John L. ...</i>			

05530 11-5-68



077507 JAN 7 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6494

1- STATE REGISTRAR		FOR DECEASED NAME		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		Raymond		Bradshaw		III				<input checked="" type="checkbox"/>		12-22		19		87		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		Black		Sept. 14, 1980		7 YRS.		MONTHS		DAYS		12-22		19		87		12:15 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.		United States		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Prince George's County, MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George's General Hospital		Student															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
D.C.		N		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1780 Lyman Place, N.E. 9999											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Raymond Bradshaw Jr.		Lueada Washington																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		Not Stated		Raymond Bradshaw Jr.		Father Same as 13e													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Multiple Injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED															
		10:20PM 12-21-87		passenger in auto/bus impact															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
		parkway		Balto.-Wash. Pkwy., Cheverly, Prince George's Co., Md.															
22a. I certify that I took charge of the remains described above, held on																			
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Charles P. Kokes, M.D.		Assistant		12-22-87															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Charles P. Kokes, M.D.		111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Burial		29 Dec 87		Lincoln Mem. Cemetery		Suitland, Maryland													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Frazier's Funeral Home		389 R.I. Avenue, N.W.		JAN 6 1988		John S. Sander													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PARAGRAPH 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DMHM - 17
(VR A15 ME (1))

075992 DEC 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36495

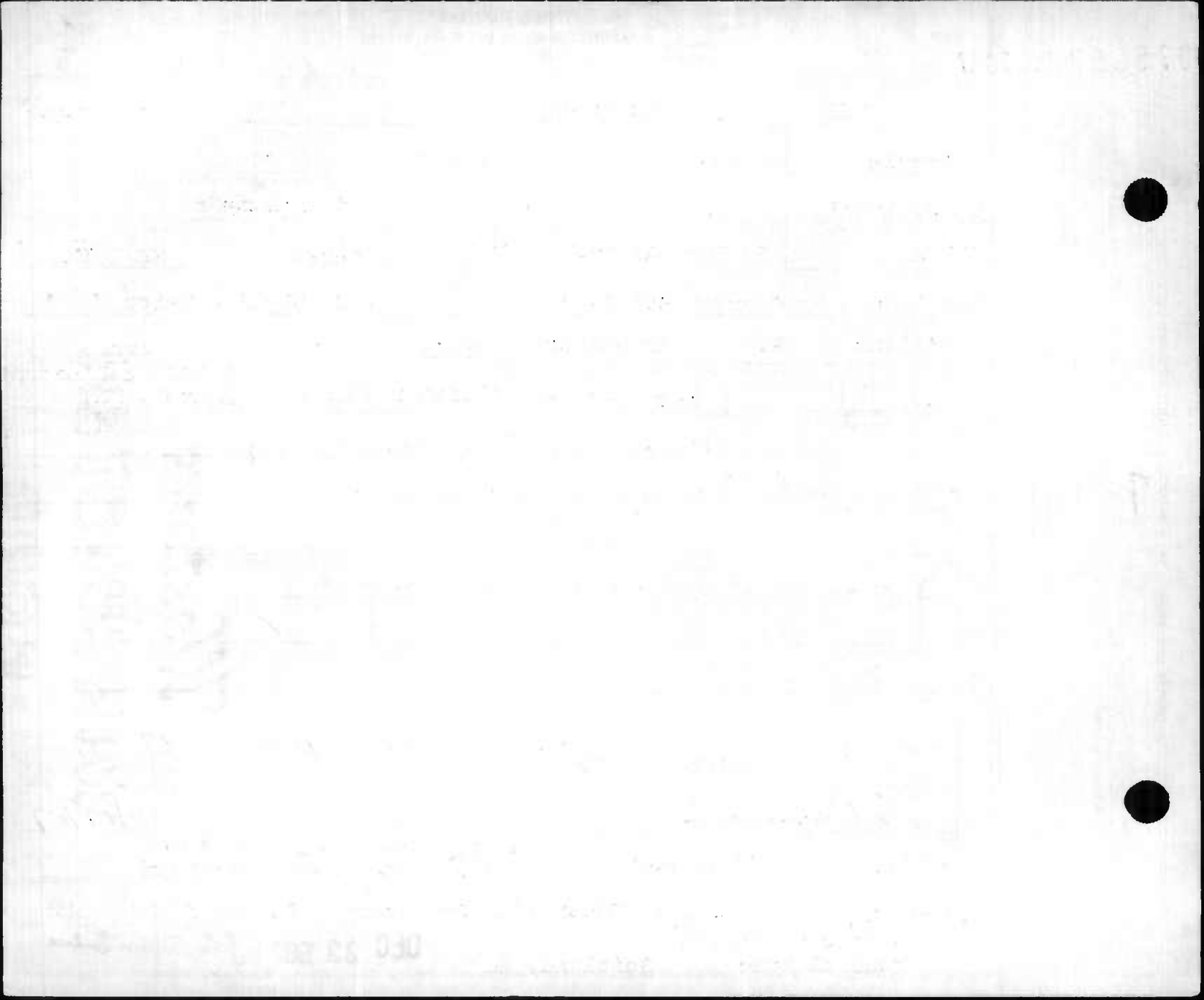
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gail B. Brittingham			2a DATE OF DEATH MONTH DAY YEAR 12 - 16 - 87		2b HOUR 11:55 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 04 - 08 - 07		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b KIND OF BUSINESS OR INDUSTRY Nursing MEDICINE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr George 13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4208 Skyline Drive 20746	
14 FATHER'S NAME FIRST MIDDLE LAST William A. Burnheimer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie M. Moore			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 164-28-8868		17. INFORMANT ADDRESS William H Stewart 12305 Mt Pleasant Laurel, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic renal failure. Malnutrition.</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>11/24</u> , 19 <u>87</u> , to <u>12/16</u> , 19 <u>87</u> , that (1) (we) lost above, (1) (we) (did) view the body after death.					
22b SIGNATURE <u>S. Jumani</u>		DEGREE MD		22c. DATE SIGNED 12/17/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SATISH N. JUMANI		22e ADDRESS 8926 WOODYARD RD #601 CLINTON, MD 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 18Dec87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland, Md		25. DATE REC'D BY REGISTRAR DEC 22 1987	
				25b REGISTRAR'S SIGNATURE <u>Jessie D. ...</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



074690 DEC 11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 6496

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Robert</i>		MIDDLE		LAST <i>Brooks</i>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>12-4-87</i>		2b. HOUR M <i>8</i>	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2-16-18</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YR. MONTHS DAYS <i>69</i>		IF UNDER 24 HRS. HOURS MIN <i>5</i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>12-4-87</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD					
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Construction Worker</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>MD.</i>		13b. COUNTY <i>Prince Geor</i>		13c. CITY OR TOWN <i>Capitol Hgt</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>4307 North Addison Road</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>231-01-8645</i>		17. INFORMANT ADDRESS <i>Colleen Boydston-4307 N. Addison Rd</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Computer (leg)</i>											
19a. DATE OF OPERATION <i>12-4-87</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>12-4-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>				23b. DATE <i>Dec. 8, 1987</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>			
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>				23e. DATE REC'D. BY REGISTRAR <i>DEC 10 1987</i>				23f. REGISTRAR'S SIGNATURE <i>John Davidson-Rendall</i>			
24. FUNERAL DIRECTOR NAME <i>John Stewart</i>				ADDRESS <i>Funeral Home 4001 Benning Rd. N.</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

711.373-062470

11-21-11

1001071 79087



Items, 5, 7a, 12a, 14, & 15, 6-634, 12/18/87 STATE OF MARYLAND
FOR by State Anatomy Board, DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE REGISTRAR Gbj.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6493

1. DECEASED NAME (PRE OR PRINT) FIRST ISIAH MIDDLE BROWN LAST		2. DATE KNOWN OF DEATH MONTH 11 DAY 22 YEAR 1987		2b. DATE KNOWN OF DEATH MONTH 11 DAY 22 YEAR 1987		2c. DATE KNOWN OF DEATH MONTH 11 DAY 22 YEAR 1987		2d. DATE KNOWN OF DEATH MONTH 11 DAY 22 YEAR 1987	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 6 DAY 6 YEAR 25	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE PRONOUNCED DEAD MONTH 11 DAY 22 YEAR 1987	7d. HOUR 7:39 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN CO.'NTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10. CITY OR TOWN OF DEATH Mt. Ranier		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bunker Hill Rd. & Rhode Island Ave.				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY unk	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS unk	
14. FATHER'S NAME FIRST Isiah MIDDLE BROWN LAST				15. MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE CHEATHAM LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 223-26-0816		17. INFORMANT		ADDRESS unk			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Seizure disorder and fatty liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Seizure disorder and fatty liver</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John E. Smialek</i>		TITLE (SPECIFY) M.D. Chief		MEDICAL EXAMINER DATE SIGNED 11-22-87	
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 12-4-87	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board Balto., Md.		25a. DATE REC'D. BY REGISTRAR DEC 07 1987	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

100-33488-147

078174 JAN 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36499

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah J Brown			2a DATE OF DEATH MONTH DAY YEAR 12/25/87		2b HOUR 3:55 AM
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR March 19, 1930		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10 CITY OR TOWN OF DEATH Clinton	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser		12b KIND OF BUSINESS OR INDUSTRY Dry Cleaners
13a STATE D. C.		13b COUNTY Washington	13c CITY OR TOWN Washington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4517 Quarles St. N. E. 99999
14 FATHER'S NAME FIRST MIDDLE LAST James Macke		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Robinson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 223-36-6169		17 INFORMANT Mary M. Wilson-Daughter-Oxon Hill, Md. 20745	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST, RECURRENT .HOURS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) SEVERE ANOXIC ENCEPHALOPATHY AND COMA .DAYS.
	(c) ACUTE PULMONARY EDEMA, RESPIRATORY FAILURE .DAYS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

DIABETES MELLIT US, HYPERTENSIVE CARDIOVASCULAR DISEASE, SEIZURE

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Dec. 13 19 87 to Dec. 25 19 87 , that (I) (we) last saw the deceased alive on DEC 25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Peter W. Yim		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED DEC. 26 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.		22e ADDRESS 7900 OLD BRANCH AVE. SUITE 101 CLINTON, MARYLAND 20735	

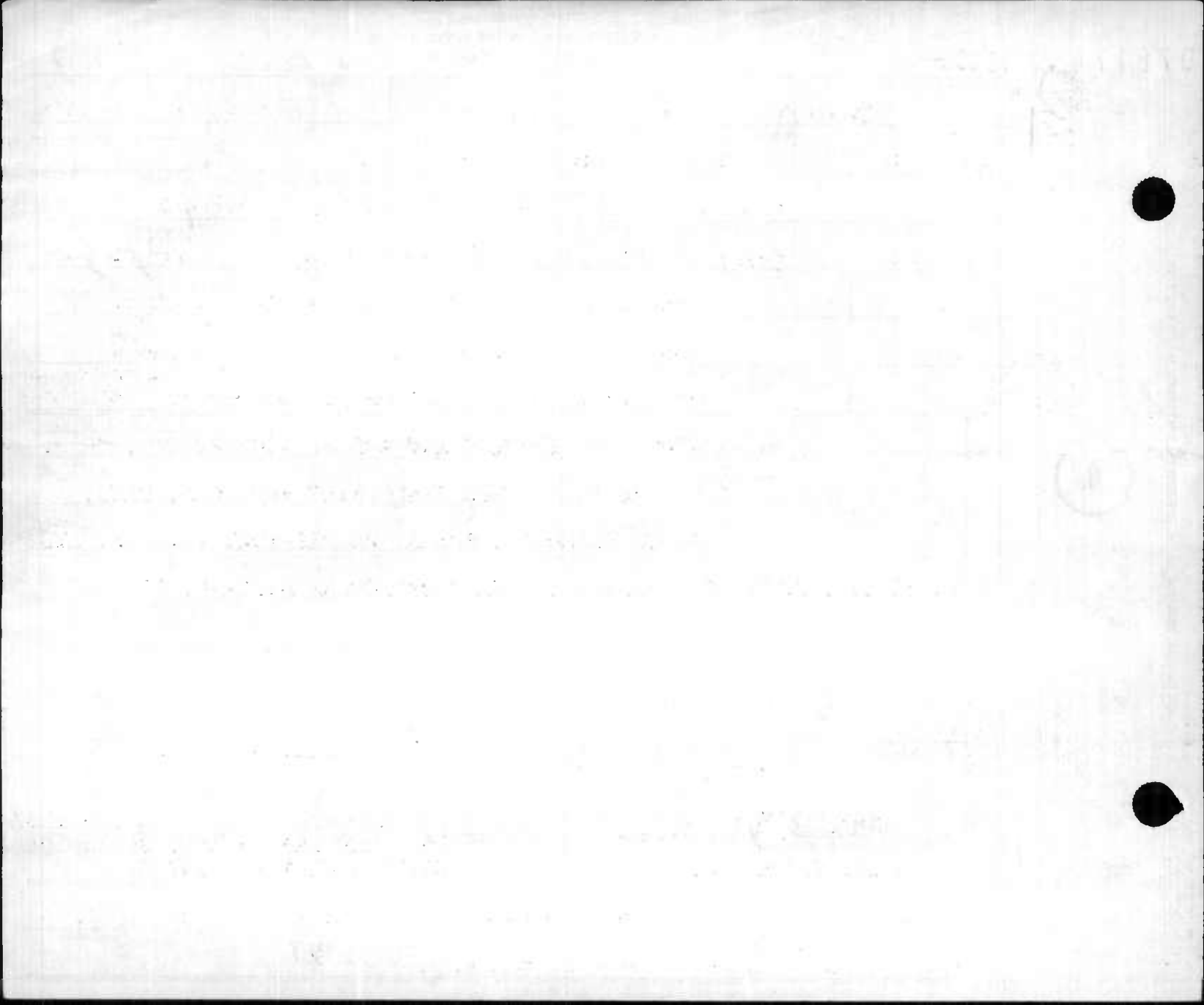
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 12-30-87	23c NAME OF CEMETERY OR CREMATORY Harmony Memo. Park	23d LOCATION CITY OR TOWN COUNTY STATE Landover, P. G. Md.
24 FUNERAL DIRECTOR NAME T. C. Pinckney		ADDRESS 524 - 8th St., N. E.	25a DATE REC'D BY REGISTRAR DEC 31 1987
24b FUNERAL HOME Spangler Funeral Home		25b REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



076643 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36500

1 DECEASED NAME (TYPE OR PRINT) Edith Grace BURNESS			2a DATE OF DEATH MONTH DAY YEAR Dec. 27, 1987			2b HOUR a 3:07				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR February 4, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD				
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P. G. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY own home		
13a STATE Maryland			13b COUNTY Pr. George's		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3904 Carvel Lane 20715	
14 FATHER'S NAME FIRST MIDDLE LAST Walter J. Evans			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ldna unk.			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - - -				
16b SOCIAL SECURITY NO. 577-14-9305B			17 INFORMANT August Burness, Jr. 8871 Good Luck Road Lanham, Maryland 20706							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE PULMONARY EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) URSEPSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 10 YEARS 6 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) (the hospital) attended the deceased from 1978, 19, to 12-27-1987, that (I) (we) last saw the deceased alive on 12-26-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE John Cosma M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED DEC 27, 1987		
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN COSMA, M.D.						22e ADDRESS 14300 CALLANT FOX LA. BOWIE, MD.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE DEC 29, 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. George's, MD			
24 FUNERAL DIRECTOR NAME Beall Funeral Home			16000 ADDRESS Bowie, MD 20715-3043		25a DATE REC'D. BY REGISTRAR DEC 30 1987		25b REGISTRAR'S SIGNATURE John Burness			

BP

076 613 DEC 31 57

Handwritten notes and stamps on lined paper, including "DEC 31 1957" and "076 613".

DEC 30 1957

074899 DEC 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6501

1. DECEASED NAME (TYPE OR PRINT) Linda R. Burt			2a. DATE KNOWN OF DEATH ESTIMATED 12/ 5/ 1987			2b. HOUR 9:07 a.m.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 13, 1923	6. AGE (IN YEARS) (LAST BIRTHDAY) 64	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 12/ 5/ 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Catitti		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esmeralda Lucci		13e. STREET ADDRESS 7307 Gavin Street				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT 7307 Gavin Street Frank W. Burt New Carrollton, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Multiple Injuries Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		APPROPRIATE APPROVAL BETWEEN ONSET AND DEATH 20784
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:23xx 12/ 5/ 1987	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject driver in auto/auto collision	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. Ave. & Upshire St., Bladensburg, Pr. Geo. Md.	

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Dennis F. Smyth* TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12/6/87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY George Washington Cem. Adelphi, Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince George's Md.
24. FUNERAL DIRECTOR NAME ADDRESS Rendon/Hale Lanham Funeral Home 9013 Annapolis Road Lanham, Maryland 20706			

DATE REC'D BY REGISTRAR 12/11/87

72 11 370 828 470

987 1 1 336

076929 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 RELEASED TO PHYSICIAN BY D.M.E. JOHN ROGERS, SILVER SPRING, MD.
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

87 REG. NO. 36502

1. DECEASED NAME (TYPE OR PRINT) Betty Jane Busler			2a. DATE OF DEATH MONTH DAY YEAR December 25, 1987		2b. HOUR 6:45 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2-19-1925		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 62		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3601 Gallatin Street		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE Maryland		13b. COUNTY Prince Geo.'s		13c. CITY OR TOWN College Pk.		
14. FATHER'S NAME FIRST MIDDLE LAST William Alfred Foster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona Kehler		13e. STREET ADDRESS / ZIP CODE 9014 Rhode Island Ave. 20740		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 151-14-1338		17. INFORMANT (Daughter) Wendy R. Gage ADDRESS 4912 42nd Avenue Hyattsville, Maryland 20781		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary artery disease. DUE TO, OR AS A CONSEQUENCE OF: (c) Chronic obstructive lung disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Moderately severe atherosclerosis.						
19a. DATE OF OPERATION 4/1/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		
22a. I certify that (I) (this hospital) attended the deceased from March 1985 to Dec. 1987 , that (I) (we) lost saw the deceased alive on Dec. 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Raman R. Tuli				22c. DATE SIGNED 12.26.87.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMAN R. TULI				22e. ADDRESS 3601 Taylor Street Brentwood MD 20722.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		23e. DATE REC'D. BY REGISTRAR DEC 31 1987				
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A.				25b. REGISTRAR'S SIGNATURE [Signature]		
4739 Baltimore Avenue Hyattsville, Md. 20781						

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076882 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36503

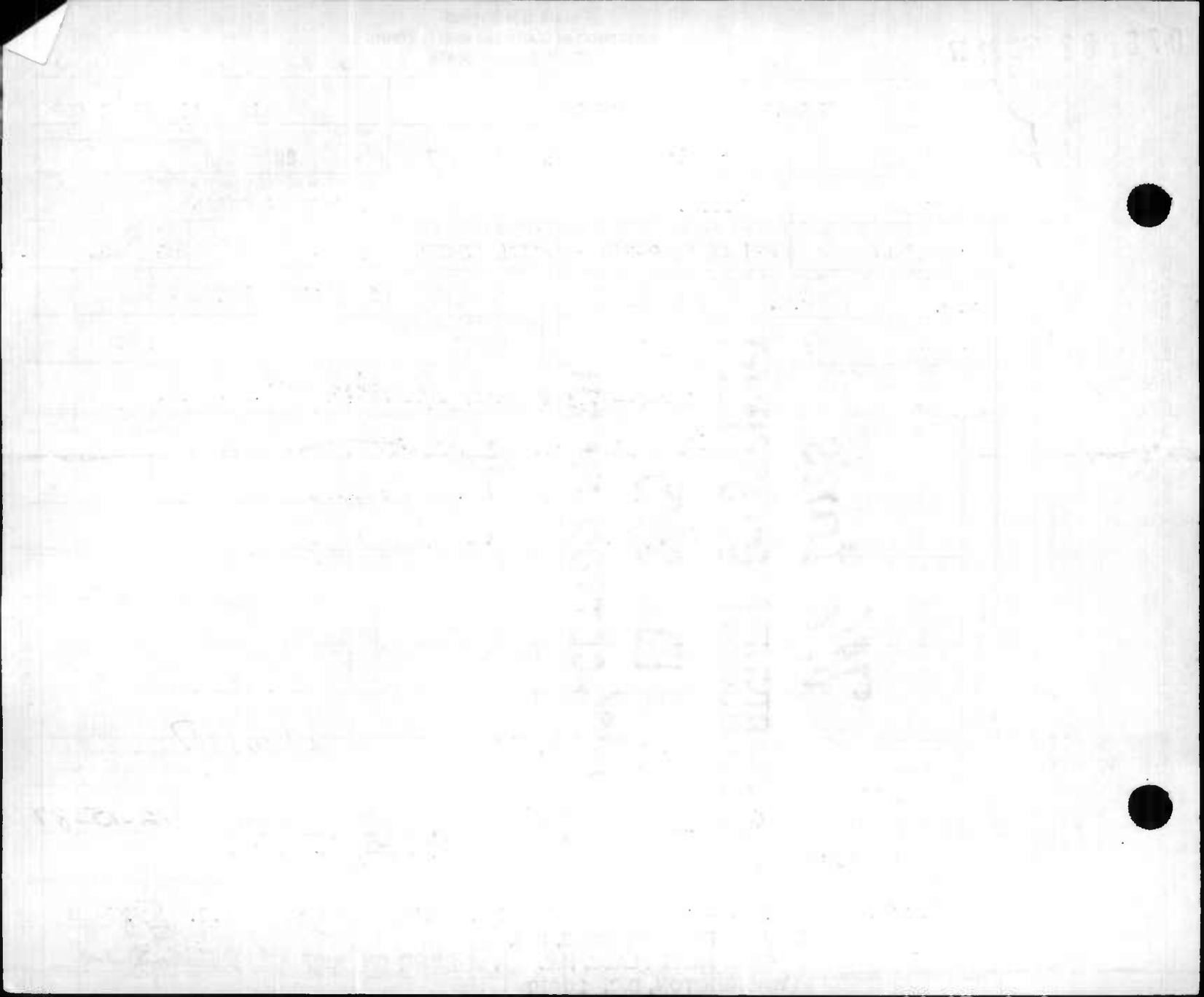
1. DECEASED NAME (TYPE OR PRINT) THOMAS BUTLER			2a. DATE OF DEATH MONTH DAY YEAR 12 11 87			2b. HOUR 1 00P M				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 06 26 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY PG BOARD OF E.D.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE M.D.			13b. COUNTY P.G.		13c. CITY OR TOWN MARLBORO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4505 ORIAN HIGHWAY 20772	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BUTLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE EFFIE ADAMS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-12-7763 A		17. INFORMANT ADDRESS 4505 ORIAN HIGHWAY IRENE BUTLER UPPER MARLBORO M.D.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/87</u> , 19 <u>87</u> , to <u>12/15/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/11/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u> M.D.						DEGREE		22c. DATE SIGNED 12-15-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. VAUGHN, M.D.						22e. ADDRESS 6492 LANDOVER RD. LANDOVER, MD. 20785				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-17-87		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON P.G. MARYLAND			
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019			25a. DATE REC'D. BY REGISTRAR DEC 28 1987			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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075810 DEC 12 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO 36504

1. DECEASED NAME (TYPE OR PRINT) Sadie Campbell			2a. DATE OF DEATH MONTH DAY YEAR 12-10-87		2b. HOUR 8:50 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12-19-99		6. AGE (IN YEARS LAST BIRTHDAY) 87	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE MARYLAND			13b. COUNTY CHARLES	13c. CITY OR TOWN LAPLATA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK McPHERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH NORRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James E. Campbell P.O. Box 1515 La Plata, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal failure - Cardiac Arrhythmia - AS HD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/26/87, 19-87, to 12/10/87, 19-87 that (I) (we) last saw the deceased alive on 12/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I did not) view the body after death.						
22b. SIGNATURE R. M. NOSTRAN				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. NOSTRAN				22e. ADDRESS 4235 24th Ave Md 20745		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION CITY OR TOWN COUNTY STATE LAPLATA CHARLES MD.
24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME				ADDRESS POMONKEY, MD		25a. DATE REC'D. BY REGISTRAR DEC 16 1987
						25b. REGISTRAR'S SIGNATURE A. A. Barber-Randall

MEDICAL CERTIFICATION

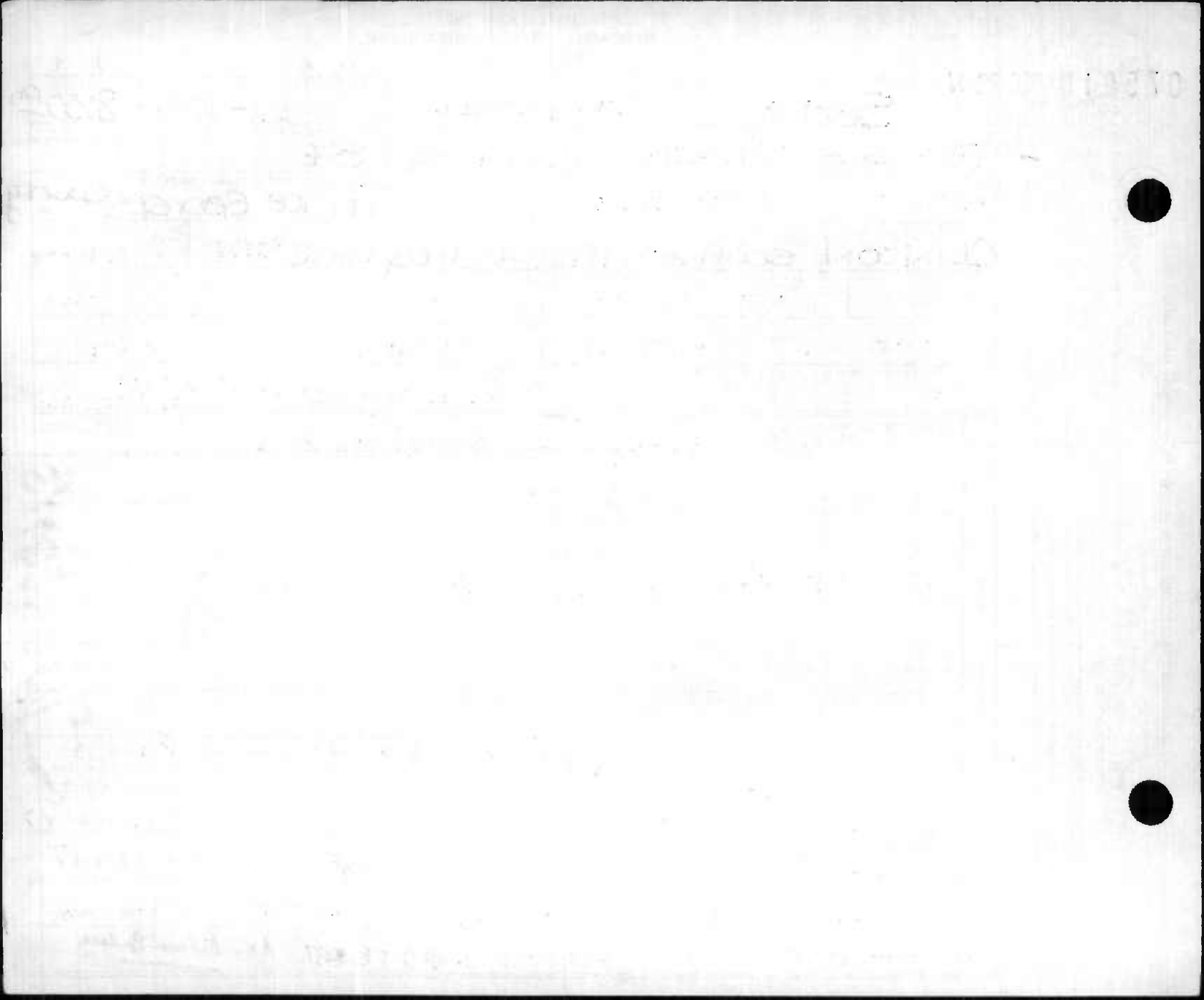
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. It should be detached for use on the burial transit permit. Then please remove carbon papers. Paper labels should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP



075334 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) EDNA B. CARDWELL			2a. DATE OF DEATH DECEMBER 11 1987		2b. HOUR 8:55 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 7, 1895		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of PR.GEO.CO.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.				
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		
14. FATHER'S NAME Charles E. Bruce		15. MOTHER'S MAIDEN NAME Ida Susan Sheplett		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-24-1104		17. INFORMANT Mary Farquhar, Same address as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcohol abuse</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 12.9.87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrostomy Feeding Tube		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12-4 1987 to 12-11 1987, that (I) (we) lost saw the deceased alive on 12-10 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 12.11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 3308 Dodge PK Rd Lanham MD		22e. ADDRESS 41 D. Circo A. Montanez				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		23e. DATE REC'D. BY REGISTRAR DEC 16 1987		23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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J.M. Johnston

IV. circumstances

Joseph G. Carter's Sons, Inc.

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578-24-1104 Gary Farmer, same address as 578-24-1104

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Bill Crowell Dr. 50816

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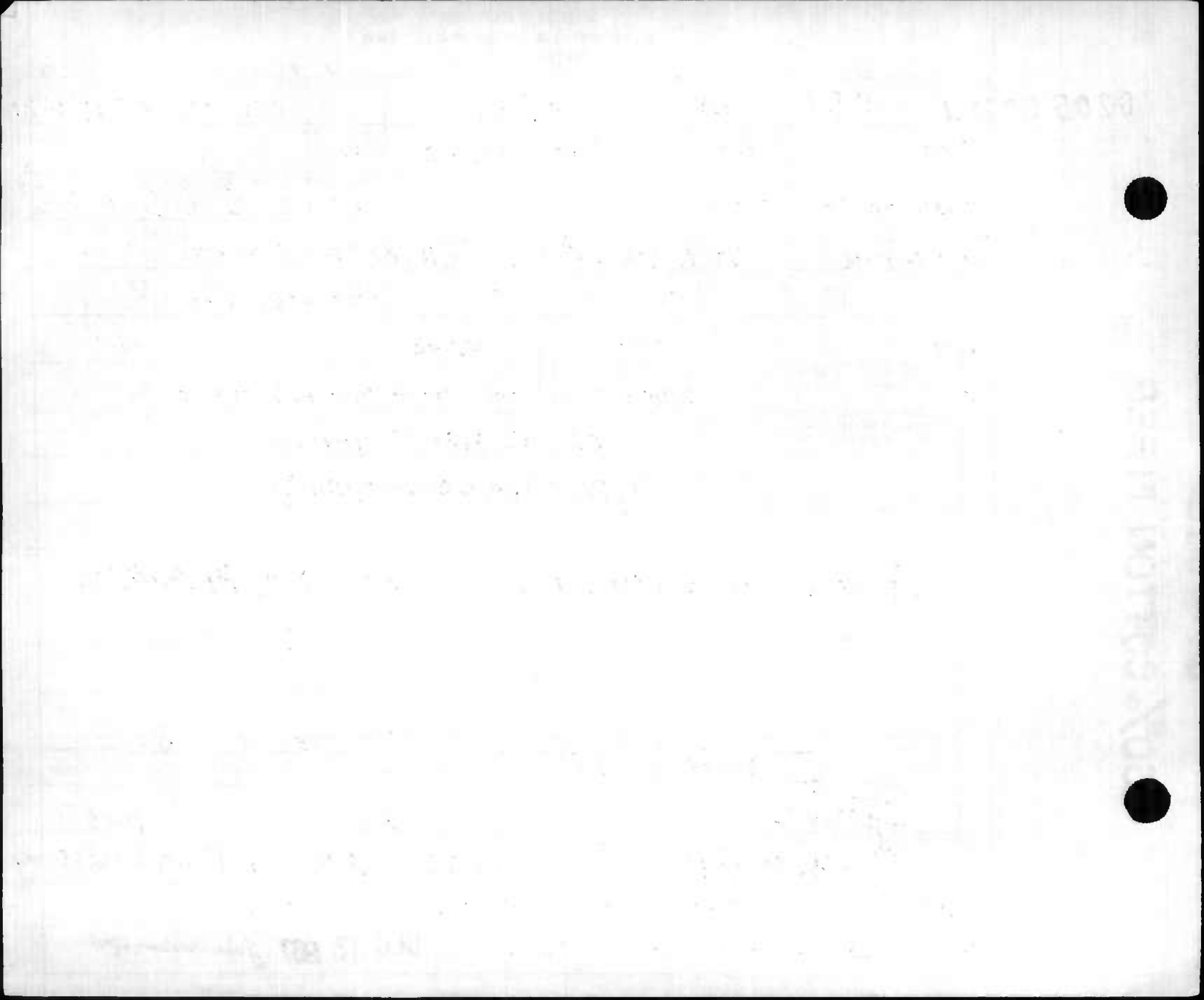
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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36506

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ORA LEE CARTER			2a. DATE OF DEATH MONTH DAY YEAR 12 16 87		2b. HOUR 11:40 AM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH SEPT. 18, 1924	6. AGE (IN YEARS LAST BIRTHDAY) 63	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES		
12. CITY OR TOWN OF DEATH ELINTON	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sima Hospital Center		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator	15. KIND OF BUSINESS OR INDUSTRY None	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Wash., D.C.	17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	18. STREET ADDRESS / ZIP CODE 5013 - 7th Place, N.W.		19. 99999	
20. FATHER'S NAME FIRST MIDDLE LAST Dave Crank	21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allean Head		22. ADDRESS David Carter (husband) same as item #13		
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	24. SOCIAL SECURITY NO. 251-38-8260	25. INFORMANT David Carter (husband) same as item #13			
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOMYOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
27. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Atherosclerotic Cardiovascular Disease Diabetic Mellitus					
28. DATE OF OPERATION	29. CONDITION FOR WHICH OPERATION WAS PERFORMED	30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)	33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 36 PART 1 OR PART 2)			
35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	37. LOCATION STREET CITY OR TOWN COUNTY STATE			
38. I certify that (I) (this hospital) attended the deceased from Dec 13 19 87 to Dec 16 19 87, that (I) saw the deceased alive on above, (I) (did) (did not) view the body after death.					
39. SIGNATURE Frank M. Ryan M.D.	40. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	41. DATE SIGNED 12/16/87			
42. PHYSICIAN'S NAME (TYPE OR PRINT) Frank M. Ryan M.D.	43. ADDRESS 9401 Indian Head High, FT. Wash, Md 20744				
44. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	45. DATE 12-22-87	46. NAME OF CEMETERY OR CREMATORY Harmony Cemetery	47. LOCATION Landover, Md. COUNTY STATE		
48. FUNERAL DIRECTOR Vanr & Williams, 4804 Ga. Ave., N.W., Wash., D.C.		49. DATE REC'D. BY REGISTRAR DEC 23 1987			



077126 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 3 5 5 0 7

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
5-89		William Martin Carter				12/19/87		8:12 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Sept. 27 1945		42 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		United States				PRINCE GEORGES			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		SOUTHERN MARYLAND HOSPITAL		Disabled		None			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Prince Georges Hillcrest		Hgt. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				(20746) 4029 - 23rd Parkway, Apt. 21	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
William Allen Carter		Betty Hassie Alderman		No		577-60-8390		219 Happytown Road, Gaston, South Carolina Russell & Annie Larimore (brother-in-law/sister)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		acute cardiopulmonary arrest						hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		(c)				days	
		Gross Negative Septicemia		acute renal failure				days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Episode of shock & coagulopathies, renal insufficiency & hypertension, SEIZURES						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED					
Nov. 18 19 87 to Dec. 19 19 87 that (I) (we) last saw the deceased alive on		Dec. 19 19 87		Dec. 20/87					
above, (I) (we) (did) (did not) view the body after death.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
		PETER W. YTM. M.D.		7900 Old Branch ave suite 101 Clinton, Maryland 20235					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Dec. 22, 1987		Lee's Crematory		Clinton, P.G.Co., Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LATNEY's Funeral Home		3831 Georgia Avenue, NW, Washington, D.C. 20011		JAN 4 1988					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

11-15-20



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6508	
1- FOR REGISTRAR										2a. DATE KNOWN OF DEATH	
DECEASED NAME (TYPE OR PRINT) Restituto Catbay, Jr.										MONTH DAY YEAR HOUR 12 24 87 M	
3 SEX Male 4. RACE Filipino 5. DATE OF BIRTH November 17, 1967 6. AGE (IN YEARS) 20s.										7b. CITIZEN OF WHAT COUNTRY? Philippine Is.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippine Is.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Oxon Hill										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Clerk	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7311 Roanne Drive										12b. KIND OF BUSINESS OR INDUSTRY Computer	
13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN Oxon Hill										13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Restituto Catbay, Sr.										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Salome Acha	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 217-13-7306	
17. INFORMANT ADDRESS Restituto Catbay, Sr. 7311 Roanne Dr. Oxon Hill, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR 12 MONTH DAY YEAR 24 87 P.M.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject hanged self	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home										21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7311 Roanne Drive, Oxon Hill, P.G. Co., MD.	
22a. I certify that I took charge of the remains described above, held in Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Mario F. Golle, Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 12/25/87	
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St. Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 1/2/88	
23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.										23d. LOCATION CITY OR TOWN COUNTY STATE Suitland p.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.										25a. DATE REC'D. BY REGISTRAR DEC 28 1987 25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

87 REG. NO. 36509

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Doody Chandler			2a. DATE OF DEATH MONTH DAY YEAR December 23, 1987		2b. HOUR 9:45A						
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR March 24, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 4 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 16708 Mattawoman Lane 20601			
14. FATHER'S NAME FIRST MIDDLE LAST John Doody		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine O'Brien		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 174-10-0998		17. INFORMANT ADDRESS Joseph G. Chandler, Jr. same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrhythmia (atrial fibrillation)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiopulmonary accident, recurrent</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOI WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 4</u> 19 <u>87</u> , to <u>DECEMBER 11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Dec. 11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Glenn R. Jaucian</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-23-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Glenn R. Jaucian, MD				22e. ADDRESS 9450 Penn Ave. #18 Upper Marlboro, Maryland 20772							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 24, 1987		23c. NAME OF CEMETERY OR CREMATORY Huntt Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.					
24. FUNERAL DIRECTOR NAME Huntt Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

Medical Examiner Dr. Rodriguez Notified and Released 12-23-87

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (I) (we) (did) (did not) view the body after death, the medical examiner must be notified at once.

077166 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG

36510

FOR
DATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Gilbert John		Check						Dec 30 1987		12		PM					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	Aug 23 1923		23 YRS.		MONTHS		DAYS		Dec 30 1987		12		PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
North Dakota		US						Prince Georges									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Laurel		Greentree Laurel Beltsville Hosp		Ret. Col.		US Army											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md. Prince Georges		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8804 Briarcroft Ln.		20708									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Check		Madeline		Piatz											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		8804 Briarcroft Ln.		Laurel, Md. 20708									
YES		1941-1967		501-42-8072		Thelma Check											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18a.																	
None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dr. J. S. Rogers										MEDICAL EXAMINER		DATE SIGNED Dec 31 1987			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										Silver Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		1/4/88		Arlington National		Arlington		Arlington		Va.							
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR										REGISTRAR'S SIGNATURE					
Fleck Funeral Home, Inc.		7601 Sandy Spring Rd.										JAN 4 1988					
NAME		ADDRESS															
Fleck Funeral Home, Inc.		Laurel, Md. 20707															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. OBTAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



075585 DEC 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36511

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
James Francis Clark Jr.		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE KNOWN OF DEATH	
Sept 12-19		68 YRS.		12-15-87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
New York		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Oxon Hill		5107 Linwood Drive		U.S. Air Force - Ret.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince George		Oxon Hill	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
James F. Clark, Sr.		Geraldine M. Noteboom		127-07-1356	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		17c. ADDRESS	
Yes		1941-1971		458 Vista Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY:		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a) <u>Hypertensive cerebrovascular disease</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
DUE TO, OR AS A CONSEQUENCE OF		P.M. 19			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
DUE TO, OR AS A CONSEQUENCE OF		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		M.D. Deputy		12-15-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct., Temple Hills, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/18/87		Arlington National Cem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George p. Kalas Funeral Home		6160 Oxon Hill Rd.		DEC 18 1987	
Oxon Hill, Md.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

175403 (C) 17

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 6 5 1 2

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

MARGARET

Kennedy Clay

2a. DATE OF DEATH

MONTH

DAY

YEAR

12

09

87

2b. HOUR

6

10A

M

3. SEX

FEMALE

4. RACE

Caucasion

5. DATE OF BIRTH

MONTH

22

YEAR

12

6. AGE (IN YEARS (LAST BIRTHDAY))

75

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington DC

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIEDWIDOWED ☐ DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD.

10. CITY OR TOWN OF DEATH

CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

PRINCE GEORGE'S HOSPITAL CENTER

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING (1FE))
Secretary

12b. KIND OF BUSINESS OR INDUSTRY

Fed. Gov'T

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Pr. Geor.

13c. CITY OR TOWN

Hyattsville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3513 Toledo Terrace #A 20782

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Daniel

J.

Kennedy

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Nora

Theresa Ganey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

578-32-4481

ADDRESS

Thomas Clay

3600 Perry Street

Mt. Rainier, Md. 20712

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Respiratory Failure

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

1 month

DUE TO, OR AS A CONSEQUENCE OF

Pneumonia

1 month

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Cerebrovascular Accident

19a. DATE OF OPERATION

N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

N/A

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

N/A

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

12/8 9/2 19 87 to 12/9 19 87 that (I) (we) lost

saw the deceased alive on

above (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

MD

ATTENDING

PHYSICIAN ☒

MEDICAL

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

12/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Don H. Yablonsky, Jr.

22e. ADDRESS

10300 Greenbelt Rd
Suite 101, Poolesville, Md 20706

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

12-12-87

23c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

23d. LOCATION

CITY OR TOWN

Brentwood

COUNTY

P.G.

STATE

Maryland

24. FUNERAL DIRECTOR

Francis Gasch's Sons, P.A.

25a. ADDRESS

4739 Baltimore Ave
Hyattsville, Md. 20781

25b. DATE REC'D BY REGISTRAR

DEC 17 1987

25c. REGISTRAR'S SIGNATURE

John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the facts and figures, and is intended to give a general impression of the work done.

2. The second part of the report is a detailed account of the work done. It is a full and complete statement of the facts and figures, and is intended to give a detailed account of the work done.

3. The third part of the report is a summary of the results of the work done. It is a brief statement of the facts and figures, and is intended to give a general impression of the results of the work done.

4. The fourth part of the report is a detailed account of the results of the work done. It is a full and complete statement of the facts and figures, and is intended to give a detailed account of the results of the work done.

5. The fifth part of the report is a summary of the conclusions reached. It is a brief statement of the facts and figures, and is intended to give a general impression of the conclusions reached.

6. The sixth part of the report is a detailed account of the conclusions reached. It is a full and complete statement of the facts and figures, and is intended to give a detailed account of the conclusions reached.

7. The seventh part of the report is a summary of the recommendations made. It is a brief statement of the facts and figures, and is intended to give a general impression of the recommendations made.

8. The eighth part of the report is a detailed account of the recommendations made. It is a full and complete statement of the facts and figures, and is intended to give a detailed account of the recommendations made.

9. The ninth part of the report is a summary of the conclusions reached. It is a brief statement of the facts and figures, and is intended to give a general impression of the conclusions reached.

10. The tenth part of the report is a detailed account of the conclusions reached. It is a full and complete statement of the facts and figures, and is intended to give a detailed account of the conclusions reached.

P

075990 DEC 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36513

1. DECEASED NAME (TYPE OR PRINT) EVA Richards Coffman			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1987			2b. HOUR 4:05 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 4 1908			6. AGE (IN YEARS LAST BIRTHDAY) 79			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greene Laurel Beltsville Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookbinder			12b. KIND OF BUSINESS OR INDUSTRY Printing U.S. Gov't		
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Petefish			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Bertha Richards			16. STREET ADDRESS / ZIP CODE 13102 Larchdale Road 20708				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Sharon Coffman/13102 Larchdale Road, Laurel Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ISCHEMIC HYPERTENSIVE HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSIVE NEPHROSCLOSIS WITH RENAL FAILURE</u>										
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10.21.1987</u> , to <u>12.14.1987</u> , that (I) (we) lost saw the deceased alive on <u>12.14.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Christine De Lima</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12.15.87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINE DE LIMA						22e. ADDRESS 14201 LAUREL PK DR. LAUREL MD 20810				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1987 December 18		23c. NAME OF CEMETERY OR CREMATORY St Luke Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodstock, Virginia Loudoun			
24. FUNERAL DIRECTOR NAME ADDRESS Dellinger Funeral Home, Inc 157 North Main Street, Woodstock, VA 22664						25. DATE RECEIVED BY REGISTRAR DEC 22 1987			25b. REGISTRAR'S SIGNATURE	

COPIES OF THIS REPORT WILL BE FURNISHED TO THE
DIRECTOR OF THE BUREAU OF RESEARCH

1. The purpose of this report is to provide a summary of the results of the research conducted during the period from January 1, 1950, to December 31, 1950. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

2. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

3. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

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8. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

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10. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

076899 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36514

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTI- MATED										2b. HOUR																																																	
DECEASED NAME (TYPE OR PRINT) <i>Frank Charles Comploier</i>										MONTH DAY YEAR <i>Dec 26 1987</i>										9 th M																																																	
3 SEX <i>M</i>			4 RACE <i>W</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>August 10 1910</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>77 YRS.</i>			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN			2c. DATE PRONOUNCED DEAD <i>Dec 26 1987</i>										2d. HOUR <i>9th</i>																																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>										MD																													
10. CITY OR TOWN OF DEATH <i>Laurel</i>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>8816 Brizicvatt Lane</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Realtor</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>																																							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE <i>MD</i>										13b. COUNTY <i>Prince Georges</i>										13c. CITY OR TOWN <i>Laurel</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <i>8816 Brizicvatt Lane</i>																			
14. FATHER'S NAME FIRST <i>Frank</i> MIDDLE <i>Comploier</i> LAST <i>Mary</i>										15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>Comploier</i> LAST <i>Laurel</i>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Navy</i>										16b. SOCIAL SECURITY NO. <i>126-14-8138</i>										17. INFORMANT ADDRESS <i>Mildred Comploier same as 13e</i>																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Acute Myocardial Dis.</i>										DUE TO, OR AS A CONSEQUENCE OF (b). <i></i>										DUE TO, OR AS A CONSEQUENCE OF (c). <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <i>None</i>										19a. DATE OF OPERATION <i>None</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										TITLE (SPECIFY) <i>Dr. P. J. Pappas</i>										DATE SIGNED <i>Dec 26/1987</i>										MEDICAL EXAMINER																																							
ACTUAL SIGNATURE <i>Dr. P. J. Pappas</i>										EXAMINER'S NAME (TYPE OR PRINT) <i>Dr. P. J. Pappas</i>										ADDRESS <i></i>										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>12/29/87</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Cemetery Jessup</i>										23d. LOCATION CITY OR TOWN <i>Howard</i> STATE <i>Md.</i>									
24. FUNERAL DIRECTOR NAME <i>Fleck Funeral Home, Inc.</i> ADDRESS <i>7601 Sandy Spring Road Laurel, Md. 20707</i>										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE <i></i>										DEC 31 1987																																							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36515

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST WILLIAM HENRY CONNER, SR.		2a. DATE OF DEATH MONTH DAY YEAR 12 23 87		2b. HOUR 6:10 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY, MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY County Employee	
13a. STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1711 S.W. Crain Highway/20772	
14. FATHER'S NAME FIRST MIDDLE LAST Leonard Edward Conner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ethel Stein					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Ruth G. Conner		ADDRESS 1711 S.W. Crain Highway, Upper Marlboro, Md. 20772			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hepato Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Cerebrovascular with Ascites</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1) SEPSIS 2) Dehydration</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-</u> 19 <u>87</u> , to <u>12-23-</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12-23-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Gursewa S. Pabla MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GURSEWA S. PABLA MD				22e. ADDRESS 8381 CHERRY LANE, LAUREL, MD 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/87		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans Cem. Cheltenham (Pr. Geo's)		23d. LOCATION CITY OR TOWN COUNTY STATE Md.			
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home				Upper Marlboro, Maryland 20772		25a. DATE REC'D BY REGISTRAR DEC 28 1987			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36516	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (FIRST MIDDLE LAST) 2887 Beatrice Edwards Cooper										2a DATE, KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-25-87	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR December 19 23 64		6 AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN.		7c DATE PRONOUNCED DEAD 12-25-87		7b HOUR 11:05 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD	
10 CITY OR TOWN OF DEATH Clinton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov.,t	
13a STATE Maryland				13b COUNTY Prince George		13c CITY OR TOWN Ft. Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 9811 Jacqueline Drive 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Nelson Edwards						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Fitzhugh					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 577 30 8633				17 INFORMANT ADDRESS Toma Locker 9811 Jacqueline Drive Ft. Washington, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: <u>Diabetic arteriosclerotic cardiovascular disease</u> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 12-25-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct, Temple Hills, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE Dec 30 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Landover Maryland P.G.			
24 FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc./7400 Georgia Ave N.W. B.C.				25a DATE REC'D. BY REGISTRAR DEC 28 1987		25b REGISTRAR'S SIGNATURE <u>Julia Gordon-Rodriguez</u>					

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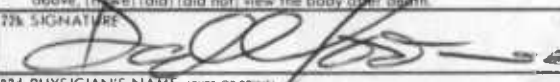
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH


87 REG. NO. 36517

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Delmer Eugene Cooper			2a. DATE OF DEATH MONTH DAY YEAR 12 18, 1987		2b. HOUR 10:00AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 3 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Oxon Hill	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 709 Crawford St. Oxon Hill, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY F.B.I.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Pr. George	13c. CITY OR TOWN Oxon Hill	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Raymond Cooper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 431-30-6112		17. INFORMANT Alpha F. Cooper	
			ADDRESS as in item 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) <u>Metastatic Colon Cancer of Liver</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OF PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 26, 19 87</u> , to <u>December 18, 19 87</u> , that (I) (we) lost saw the deceased alive on <u>December 8, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (these) (did) (did not) view the body after death.			
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dal Yoo M.D.		22e. ADDRESS 1160 Varnum St. N.E. #209 Washington, D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-22-87	23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR DEC 21 1987
		25b. REGISTRAR'S SIGNATURE 	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36518
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elton Virginia Corbin			2a. DATE OF DEATH MONTH DAY YEAR 12/5/87		2b. HOUR 8:05 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 5, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9700 Autoville Drive 20740	
14. FATHER'S NAME FIRST MIDDLE LAST William Burkholder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Heatwole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-76-2494		17. INFORMANT 11000 Montgomery Road Beltsville, Maryland 20705	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/14/87 to 12/5/87 that (I) (we) lost saw the deceased alive on 11/14/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Surinder Singh		DEGREE		22c. DATE SIGNED 12/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURINDER SINGH		22e. ADDRESS 11000 Montgomery Road Beltsville, Md.		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/08/87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25. DATE REC'D BY REGISTRAR DEC 9 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WILLIAMSON

DEC 19 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36519

1. FOR STATE REGISTRAR											
1a. DECEASED NAME (TYPE OR PRINT) <u>Pedro M. Cordero</u>						2a. DATE KNOWN OF DEATH <u>Dec 1 1987</u>		2b. HOUR <u>8:22</u>		2c. MONTH <u>Dec</u>	
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>Dec 3 26 60</u>		6. AGE (IN YEARS) <u>26</u>		7. IF UNDER 1 YR. MONTHS <u>0</u> DAYS <u>0</u>		7. IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington, D.C.</u>				9. CITIZEN OF WHAT COUNTRY? <u>US</u>				10. DATE PRONOUNCED DEAD <u>Dec 1 1987</u>			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <u>Greater Laurel Beltsville Hosp</u>				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Salesman</u>				13. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Suppl.</u>			
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						15. STREET ADDRESS <u>20745 Summit Lane</u>					
16a. STATE <u>Md</u>		16b. COUNTY <u>Prince Georges</u>		16c. CITY OR TOWN <u>Laurel</u>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS <u>20745 Summit Lane</u>		16f. CITY OR TOWN <u>Laurel</u>	
17. FATHER'S NAME FIRST <u>Manrique</u> MIDDLE <u>Cordero</u> LAST <u>Cordero</u>				18. MOTHER'S MAIDEN NAME FIRST <u>Conchita</u> MIDDLE <u>Sanmillian</u> LAST <u>Sanmillian</u>							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>YES</u>				19b. SOCIAL SECURITY NO. <u>579-42-5551</u>				19c. INFORMANT ADDRESS <u>June Cordero same as 13e</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John R. Rogers</u>				TITLE (SPECIFY) <u>Dep</u>				DATE SIGNED <u>Dec 1, 1987</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>Dr. John R. Rogers</u>				ADDRESS <u>1919 Seminary Rd. Silver Spr., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>12/4/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				23d. LOCATION <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR NAME <u>Fleck Funeral Home, Inc.</u> ADDRESS <u>7601 Sandy Spring Road Laurel, Md. 20707</u>						25a. DATE REC'D. BY REGISTRAR <u>DEC 03 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IT IS TO BE FILED IN THE MEDICAL EXAMINER'S OFFICE. DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. BRING PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

074031 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

708-331-180450

076625 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36520
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LINA M. CORVOISIER			2a. DATE OF DEATH MONTH DAY YEAR 12 27 87		2b. HOUR 1:40 P.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 15, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HAITI	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH ADELPHI	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRESIDENTIAL WOODS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11737 COLLEGE VIEW DRIVE 20851	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS MCGUFFIE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUGENIE LEGENDRE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-68-4757		17. INFORMANT ADDRESS JEAN CARLO CORVOISIER/SON/SAME AS 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CEREBRO VASCULAR DUE TO, OR AS A CONSEQUENCE OF (c) AND CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 31 JULY 19 87 to 27 DEC 19 87 , that (I) (we) last saw the deceased alive on 4 DEC 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE Walter E. Goode MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 28 DEC 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODE MD		22e. ADDRESS 2309 SHOREFIELD ROAD WHEATON MD 20902	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC 30, 1987	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY ROCKVILLE MONTGOMERY MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE RECEIVED BY REGISTRAR DEC 30 1987	

BP
DHMH - 16 50M 4/B2
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1900

070021

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REPORTING OFFICER
BY THE SECRETARY
AND COMMISSIONER OF THE STATE

OFFICE OF THE
COMMISSIONER OF THE STATE

30% COTTON



REPORTING OFFICER
BY THE SECRETARY
AND COMMISSIONER OF THE STATE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Patricia T. Cousin			2a. DATE OF DEATH MONTH DAY YEAR Dec. 31, 1987		2b. HOUR 12:50A.M.				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 15, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 48		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PG			
10. CITY OR TOWN OF DEATH Largo, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 115 Harry Truman Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Nurse	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Largo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 115 Harry Truman Drive 20783	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Wells				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flossie R. Vinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243 68 7742		17. INFORMANT ADDRESS Edward Cousin-husband-115 Harry					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural Causes.								APPROXIMATE TIME BETWEEN ONSET AND DEATH 11:00 AM	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Post Craniotomy, Seizure Disorder, Vegetative State									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7500 Greenway, Cntr. Dr. Greenbelt, Md. 20770.					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1987 to Dec 30, 1987 that (we) lost saw the deceased alive on Dec. 28, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stuart Tucker				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Tucker				22e. ADDRESS 7500 Greenway, Cntr. Dr. Greenbelt, Md. 20770.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 5, 1988		23c. NAME OF CEMETERY OR CREMATORY White Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mevane, N.C.			
24. FUNERAL DIRECTOR NAME Stewart				24b. DATE REC'D. BY REGISTRAR JAN 6 1988		25. REGISTRAR'S SIGNATURE Julia Davidson-Rodale			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, separate carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

077305 JAN 7 1988

177802 11-7-78

JOHN HOLLAND & CO

JAN 8 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

074900 DEC 14 87		Item 1, 6636 2-24-88 dw		STATE OF MARYLAND		87		36522	
1- STATE REGISTRAR		per funeral home		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH		REG. NO.	
1 DECEASED NAME FIRST MIDDLE LAST Helen RUTH Craig				2a. DATE OF DEATH MONTH DAY YEAR DEC 6, 1987		2b. HOUR 3:15 PM			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Seabrook		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9510 Mazzoni AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9510 Mazzoni Ave. 20706	
14. FATHER'S NAME FIRST MIDDLE LAST Howell Samuel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Fairley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-3276		17 INFORMANT William L. Craig Sr. same as 13e		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11c									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> 19 <u>87</u> to <u>DEC</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Janet S. Martin</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-7-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet S. Martin MD.				22e. ADDRESS 6510 Kenilworth Ave - Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24 FUNERAL DIRECTOR Rendon/Hale Lanham Fun'l Home 9013 Annapolis Rd. Lanham, Md. 20706									

BP

DEC 11 1987
DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE
Julia Rendon-Rendon

5011000 000000

RECEIVED THE SECRETARY OF THE ARMY
WASHINGTON, D.C. 20315

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[The body of the letter contains several paragraphs of text that are mostly illegible due to fading and bleed-through. Some words like "The following information" and "is being furnished" are faintly visible.]

DEC 11 1950

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36523

DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
John K CRAWFORD			December 31, 1987			10:09P M		
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	June 25, 1917	70			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Montana	US			Prince George's MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Lanham	Doctors Hospital of Lanham			Gov't Ret.			Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN		
Md.			A.A.			Severn		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Kindrick			Edith			Dorothy Polson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes			Korean			403-01-7183		
			17. INFORMANT			ADDRESS		
			Carole Crawford			same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). ACUTE CARDIO PULMONARY								
DUE TO, OR AS A CONSEQUENCE OF ACUTE PULMONARY ED								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BIVENTRICULAR FAILURE								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OLD MYOCARDIAL INFARCTION CHRONIC BRONCHITIS								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1987 to 12/31, 1987, that (I) (we) last saw the deceased alive on 12/31, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
AS Rao MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Arnon S. Rao								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. LOCATION		
Burial			1/6/87			Md. Vet's cemetery Crownsville A.A. Md.		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		
7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20701						JAN 5 1988		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The lot requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove portion papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

7752-10-213

Director
Mr. J. Edgar Hoover
Federal Bureau of Investigation
Washington, D. C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum from the Bureau of the Census, dated and captioned as above.
Very truly yours,
[Signature]
[Title]

[Faint, mostly illegible text in the main body of the letter, appearing to be a memorandum format with multiple lines of text.]

Very truly yours,
[Signature]
[Title]
[Faint text at the bottom of the page, possibly a distribution list or administrative notes.]

075444 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36524

1. DECEASED NAME (TYPE OR PRINT) Marshall James CRAWFORD			2a. DATE OF DEATH MONTH DAY YEAR December 13, 1987		2b. HOUR 7:30 PM
3. SEX Male d	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 16, 1909		6. AGE [IN YEARS (LAST BIRTHDAY)] 78 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital of PR.GEO.CO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Colonel		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force
13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Crawford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Bonter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 050-03-6615		17. INFORMANT ADDRESS Jeanne M. Mullady, Same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, severe emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/13 19 87 to 12/13 19 87 , that (I) (we) last saw the deceased alive on 12/13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Dakheel M.D.				22c. DATE SIGNED 12/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel, M.D.				22e. ADDRESS Suite 121 14300 Gallant Fox Lane, Bowie, Md. 20715	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Prince George, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 17 1987			
24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16000 Annapolis Rd Bowie, Maryland 20715					

BP

01244 DEC 1961

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

Re: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

074398 DEC-98

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and signed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		M											
JOSEPH		THEODORE		CROWN		SR		December		1		1987		7:50A															
3 SEX		4 RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS													
Male		White		July 1, 1908								79 YRS.																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH																					
Washington DC		USA				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's										MD											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																							
Lanham		AMI Doctors' Hospital of Pr. Geo Co		Crime Reporter		Newspaper																							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE																			
Maryland		Pr George		Seat Pleasant				NO <input type="checkbox"/>		6012 Crown Street 20743																			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME																											
John		Curtis		Crown		Alta		Frazier																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS																							
NO		578-10-2310		Gladys M. Crown		Same as #13																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>60 days</u>																			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <u>Shock</u> <u>60 days</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disrupted Vasculature</u> <u>60 days</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> , 19 <u>87</u> , to <u>12/1</u> , 19 <u>87</u> , that (I) <u>lost</u> saw the deceased alive on <u>11/30</u> , 19 <u>87</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>lost</u> (did not) view the body after death.																													
22b. SIGNATURE <u>Jack C Meshel</u>										DEGREE <u>MD</u>										22c. DATE SIGNED <u>12/1/87</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Meshel, M.D.										22e. ADDRESS 5806 Baltimore Ave., Hyattsville, Md. 20781																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY STATE													
Burial				4 Dec 1987				Washington National				Cemetery Suitland				PG MD													
24. FUNERAL HOME NAME										24b. DATE RECEIVED BY REGISTRAR										24c. REGISTRAR'S SIGNATURE									
Robert E Wilhelm Funeral Home										DEC 7 1987																			
Suitland, Md.																													

TO THE HONORABLE SENATE
OF THE UNITED STATES

IN SENATE,
January 1, 1908.

REPORT
OF THE

COMMISSIONERS OF THE
LAND OFFICE

FOR THE YEAR
1907

AND
FOR THE YEAR
1908

IN
RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 1, 1907

AND
A RESOLUTION PASSED
BY THE HOUSE OF REPRESENTATIVES
MAY 1, 1907

AND
A RESOLUTION PASSED
BY THE HOUSE OF REPRESENTATIVES
MAY 1, 1907

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BY THE HOUSE OF REPRESENTATIVES
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BY THE HOUSE OF REPRESENTATIVES
MAY 1, 1907

078719 JAN 1988

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36526

DECEASED NAME (TYPE OR PRINT) EVELYN PADUA CUBE			2a. DATE OF DEATH MONTH DAY YEAR DEC. 25, 1987		2b. HOUR M
3. SEX FEMALE	4. RACE FILIPINO	5. DATE OF BIRTH MONTH DAY YEAR APRIL 11, 1938	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MANILA PHILIPPINES	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH JHG MD.		
10. CITY OR TOWN OF DEATH OXON HILL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9606 WEDGEWOOD PL. OXON HILL MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN OXON HILL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST REGINO PADUA PADUA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABEL G PADUA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 469-48-3521		17. INFORMANT ADDRESS BIENVENIDO CUBE 9606 WEDGE WOOD PL OXON HILL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>12/25</u> , 19 <u>87</u> , that (I) (we) lost <u>now</u> <u>the deceased</u> alive on <u>12/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Leon P. Parnowski</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/25/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL ENTOMBED</u>		23b. DATE <u>12/26/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>CLINTON PG MD</u>		25a. DATE REC'D. BY REGISTRAR JAN 18 1988			
24. FUNERAL DIRECTOR NAME <u>Chilly Bell</u>		25b. REGISTRAR'S SIGNATURE <u>James E. Parnowski</u>			
26. FUNERAL HOME <u>LEWIS FUNERAL HOME 311 N. PATRICK ST. ALEX. VA. 22314</u>					



DM
[Handwritten mark]

EDIT VICTORIAN



W. R. N. H.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 3 6 5 2 7
REG. NO.

5 DECEASED NAME (PRINT) Catherine		FIRST Curtis		MIDDLE Curtis		LAST Curtis		2a DATE OF DEATH MONTH DAY YEAR 12-29-1987		2b HOUR M	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 17 17		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS 70		IF UNDER 24 HRS. HOURS MIN. 70	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PG		MD.			
10 CITY OR TOWN OF DEATH Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4503 Cedell Place		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY Unknown					
13a STATE Md.		13b COUNTY PG		13c CITY OR TOWN Temple Hills		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4503 Cedell Pl. 20748			
14 FATHER'S NAME FIRST MIDDLE LAST Henry Washington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Williams									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 579-38-9695		17 INFORMANT Ms. Evelyn Turner/daughter/same as 13e		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 6 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 87 , to 12/29 , 19 87 , that (I) (we) last saw the deceased alive on 12/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE DN Aron Primack / M.D.								DEGREE MD		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aron Primack, M. D.				22e. ADDRESS 5454 Wisconsin Avenue, N.W. Rm. 835							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-2-88		23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Landover, Md.					
24 FUNERAL DIRECTOR NAME ADDRESS John T. Rhines Co., 3015 12th St. N.E.D.C. 20017				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE John T. Rhines					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING-PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. This permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36529

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MICHAEL MATTHEW DASKIEVIGE			2a. DATE OF DEATH MONTH DAY YEAR 12-17-87		2b. HOUR (11:00 A.M.)							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 16 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. UNDER 1 YEAR MONTHS DAYS YRS		7. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.						
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b. KIND OF BUSINESS OR INDUSTRY Fed'l. Gov't.				
13a. STATE Maryland				13b. COUNTY Pr. Georges		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5621 Belmont Dr. 20745		
14. FATHER'S NAME FIRST MIDDLE LAST Ignatious Daskievige				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rose Blaschak								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT Rose C. Daskievige		ADDRESS as in item 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Small cell lung cancer with metastasis to bone, bone marrow, skin, and pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 87 to Dec 17 87, that (I) (we) last saw the deceased alive on 12-16-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Kai-Yu Young, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-17-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yu YOUNG, MD						22e. ADDRESS 8826 Woodyard Rd #201 Clinton, MD 20734						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-21-87		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.						25. DATE RECEIVED BY REGISTRAR DEC 21 1987		25. REGISTRAR'S SIGNATURE Julia Gordon-Randall				

BP

From the ...

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8136529
REG. NO.1- FOR
STATE
REGISTRAR

7- DECEASED NAME (TYPE OR PRINT) William L.A. Davidson, Sr.		2a DATE OF DEATH MONTH 12 DAY 22 YEAR 87		2b HOUR 3:45 P.M.	
3 SEX male	4 RACE BLACK	5. DATE OF BIRTH MONTH 03 DAY 28 YEAR 20		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PG MD.	
10 CITY OR TOWN OF DEATH Hyattsville, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor Nsg Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY PG	13c CITY OR TOWN West Hyattsville	13d INSIDE CITY LIMITS? <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 802 Berkshire Drive		20783			

14 FATHER'S NAME FIRST Adolphus A. MIDDLE Davidson LAST Davidson		15. MOTHER'S MAIDEN NAME FIRST Sallie N. MIDDLE Wilson LAST Wilson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 245 18 7518	
17a MARYLAND ADDRESS 802 Berkshire Drive West Hyattsville, Md.		17b DAUGHTER- Davida A. Davidson-daughter-	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		monitory & debility 12/15/87
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of prostate & metastases		1984

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended and deceased from 12/25/87 to 12/27/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I did not) view the body after death.			
22b SIGNATURE George W. Sime, MD		DEGREE MD	22c DATE SIGNED 12/22/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) George W. Sime, MD		22e ADDRESS 2139 George Ave N.W. S.W.	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Dec. 28, 1987	23c NAME OF CEMETERY OR CREMATORY Rozek Creek Cemetery	23d LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE
24 FUNERAL DIRECTOR NAME John Stewart ADDRESS Funeral Home-4001 Benning Road,		25a DATE REC'D. BY REGISTRAR JAN 6 1988	25b REGISTRAR'S SIGNATURE Julia Davidson-Randall

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011306

075878 DEC 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36530

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
LAURA		Frances		DAVIS				ESTIMATED <input checked="" type="checkbox"/>		12		13		19		87	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY	
Female		Cau.		May 20, 1914		73 YRS.						12		13		19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Wash D.C.		U.S.A.				Prince Georges											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Clinton		Southern Maryland Hospital Center		Key Punch Operator		U.S. Govt											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 192, Davis Road 20601									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Bela		Steven		Feeney		Sarah		May		Schafer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		577-09-9553		Cleo Helland		Box 191 H. Davis Road Waldorf, Md. 20601											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		ADULT respiratory distress syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				(b)		squamous cell carcinoma of the esophagus,											
				(c)		status post esophagectomy											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
Fracture of the Femur, Chronic Obstructive Pulmonary Disease																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
11/18/87, 12/3/87		right femoral fracture, esophageal carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		? P.M. 11 14 1987		fell while walking from bathroom													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
		home		Box 192, Davis Rd., Waldorf, Charles Co., MD													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
Augusto P. Rodriguez		M.D. Deputy				12/14/1987											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		Dec 16, 1987		Christ Epis. Cem.		Accokeek, P.G., Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Huntt Funeral Home		P.O. Box 156 Waldorf, Md. 20601		DEC 21 1987		Julia Anderson-Rodriguez											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WORLD WIDE COMMUNICATIONS

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ROBERT HODGSON

WORLD WIDE COMMUNICATIONS

WORLD WIDE COMMUNICATIONS



Robert Hodgson

DEC 31 1981

075864

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH6736531
REG. NO.

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Edna B. Dean			2a. DATE OF DEATH MONTH DAY YEAR Dec. 11, 1987		2b. HOUR 3 ⁵³ AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 6 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 VRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Riverdale Md. MD
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If within such facility, give street address) Leland Hospital		12a. USUAL OCCUPATION (Type or Print, Give Most of Working Life) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13b. STATE D.C.		13c. COUNTY N		13d. CITY OR TOWN Washington		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Lee Trueheart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Jane Hill		16. STREET ADDRESS / ZIP CODE 5156 3rd St. N.W. 99999		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If YES, GIVE WAR OR DATES) No		18b. SOCIAL SECURITY NO. 578-34-5757		17. INFORMANT NAME ADDRESS Mary D. Jordan 1263 Emerson St. N.E.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE & SEVERE ANGINA & SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (c) Aneurysm, Atherosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: VASCULITIS DUE TO MIXED CONNECTIVE TISSUE DISEASE, MARROW GASTROINTESTINAL DISEASE, FAILURE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10-14-87, 19 to 12-10-87, 19 that (I) (we) last saw the deceased alive on 12-10-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Moham. med A. Mannan MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12.12.87		
22d. PHYSICIAN'S NAME (Type or Print) MOHAMMED A. MANNAN		22e. ADDRESS 3715 RHODE ISLAND AVE MT. RAINIER, MD. 20712				
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 12-17-87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Sullivan Md.
24. FUNERAL DIRECTOR NAME 3605 15th St NW Wash DC		24b. ADDRESS 15th St NW Wash DC		25. DATE RECD. BY REGISTRAR DEC 21 1987		25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 6 5 3 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude XXX De Carlo			2a. DATE OF DEATH MONTH DAY YEAR December 1, 1987		2b. HOUR 10:30 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 29, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 98	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctor's Hospital of P.G. Cty		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer.	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Michael Lilly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Reilly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 262-43-8399		17. INFORMANT ADDRESS Angela M. Laurenzano, Same as # 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9/2 IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Confusion - delirium</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from <u>11/30</u> 19 <u>87</u> to <u>12/1</u> 19 <u>87</u> , that (I) <u>did</u> did not view the body after death.					
22b. SIGNATURE <u>Robert A. DePetrakis</u>				22c. DATE SIGNED 12-1-87	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. DePetrakis MD				22e. ADDRESS 14300 GALLANT FOX LA #122 Bowie Md 20715	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 4, 1987	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Prince Geo., Maryland
24. FUNERAL DIRECTOR NAME Beall Funeral Home			25a. DATE REC'D. BY REGISTRAR DEC 02 1987		
16000 Annapolis Road Bowie, Maryland 20715			25b. REGISTRAR'S SIGNATURE <u>Julia S. ...</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

013000 DEC 30



DEC 30 1950

076463 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36533

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agustin Viloria delaCuesta			2a. DATE OF DEATH MONTH DAY YEAR December 19, 1987		2b. HOUR 6:10 P _M
3. SEX Male	4. RACE 8	5. DATE OF BIRTH MONTH DAY YEAR July 29, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phillippines	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Geo. 13c. NEW OR TOWN Carrollton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5707 84th Ave. 20784	
14. FATHER'S NAME FIRST MIDDLE LAST Anacleto M. deLaCuesta			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Faustina Viloria		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-74-9542	17. INFORMANT ADDRESS Epifania B. de la Cuesta same as 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>emassia intra Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-17</u> 19 <u>87</u> , to <u>12-19</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr J. L. G. L.</u>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12.20-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/23/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood, Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home		25a. DATE REC'D. BY REGISTRAR DEC 28 1987	25b. REGISTRAR'S SIGNATURE <u>John Swindon-Randall</u>
9013 Annapolis Rd. Lanham, Md. 20706			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be kept in the funeral director's office until it is filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 3 to the funeral director. (If the funeral director is not the one who should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 21B shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

87 REG. NO. 36534

1. DECEASED NAME (TYPE OR PRINT) Warren E. Didra			2a. DATE OF DEATH MONTH DAY YEAR December 09, 1987		2b. HOUR 7:30 A.M.
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11-24-1926	6. AGE (IN YEARS LAST BIRTHDAY) 61	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4905 Greencastle Rd. 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Adam Didra		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arlina May			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes WWII		16b. SOCIAL SECURITY NO. 579-32-5364	17. INFORMANT Mary Didra ADDRESS same as #13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) prostate cancer					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/9 1987 to 12 1987, that (I) (we) lost saw the deceased alive on 12/9 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Maximo. Wertz				22c. DATE SIGNED 12/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin O. Wertz				22e. ADDRESS 7025 Greenway Co Brum Greenbelt MD 20770	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-10-1987	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax VA.		
24. FUNERAL DIRECTOR Donald Borgwardt		4400 Powder Mill Road Beltsville, Maryland 20705		25a. DATE REC'D. BY REGISTRAR DEC 14 1987	
25b. REGISTRAR'S SIGNATURE J. Davidson-Rodale					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages retained should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified *immediately*.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH		2c. HOUR	
FIRST MIDDLE LAST		ELIZABETH G. DIGGS				MONTH DAY YEAR		12 21 87	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Black		Jan. 31, 1933		54 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.		U.S.A.				PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION							
CHEVERLY		PRINCE GEORGES HOSPITAL CENTER							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Chauffer		G.S.A.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?	
		Md.		P.G.		Glenarden		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13f. STREET ADDRESS / ZIP CODE					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		7913 Echols Ave. 20706					
Desmond Jones		Lizzie (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		242-60-8292		Charles T. Diggs-Same as # 13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>infection</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cervical cancer</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>sepsis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 21</u> 19 <u>87</u> to <u>Dec 21</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>Dec 21</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>D. J. HAIDAK</u>		MD		<u>Clinton Md</u>		<u>12/25/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
		12/28/87		CHELTENHAM VETS. CEM.		CITY OR TOWN COUNTY STATE			
				CHELTENHAM					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME			
NAME ADDRESS									
H. S. WASHINGTON + SONS 4925 BURROUGHS AVE		DEC 30 1987							

076901 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- REGISTRAR									
2- DECEASED NAME (TYPE OR PRINT) William Henry Dixon									
3- SEX M 4- RACE W 5- DATE OF BIRTH Jan. 24, 1923 6- AGE (IN YEARS) 64 7- IF UNDER 1 YR. NO 8- IF UNDER 24 HRS. NO 9- DATE KNOWN OF DEATH Dec 24, 1987 10- DATE PRONOUNCED DEAD Dec 24, 1987 11- TIME OF DEATH 11:00 P.M. 12- TIME OF DEATH 11:00 P.M.									
13- BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. 14- CITIZEN OF WHAT COUNTRY? USA 15- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 16- BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.									
17- CITY OR TOWN OF DEATH Laurel 18- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greene Laurel/Beltsville Hosp. 19- USUAL OCCUPATION (TYPE OF WORK) Production Mgr. 20- KIND OF BUSINESS OR INDUSTRY Windows									
21- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 22- STATE Md. 23- COUNTY Howard 24- CITY OR TOWN Laurel 25- INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 26- STREET ADDRESS 9650-L Barrellhouse Rd.									
27- FATHER'S NAME William Dixon 28- MOTHER'S MAIDEN NAME Goldie Herb									
29- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) n/a 30- SOCIAL SECURITY NO. 142-12-0637 31- INFORMANT Marjorie Dixon 32- ADDRESS same as 13e									
33- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
34- DATE OF OPERATION None 35- CONDITION FOR WHICH OPERATION WAS PERFORMED? None 36- AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
37- EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19 38- TIME OF INJURY 19 39- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19									
40- INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 19 41- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 19 42- LOCATION 19 CITY OR TOWN 19 COUNTY 19 STATE 19									
43- I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
44- ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. MEDICAL EXAMINER [Signature] DATE SIGNED Dec 25, 1987									
45- EXAMINER'S NAME (TYPE OR PRINT) [Signature] ADDRESS [Signature]									
46- BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 47- DATE 12/28/87 48- NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery 49- LOCATION Laurel 50- COUNTY P.G. 51- STATE Md.									
52- FUNERAL DIRECTOR 7601 Sandy Spring Rd. 53- DATE REC'D. BY REGISTRAR DEC 31 1987 54- REGISTRAR'S SIGNATURE [Signature]									
55- FIECK Funeral Home, Inc. Laurel, Md. 20700									

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Henry

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Howard

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John

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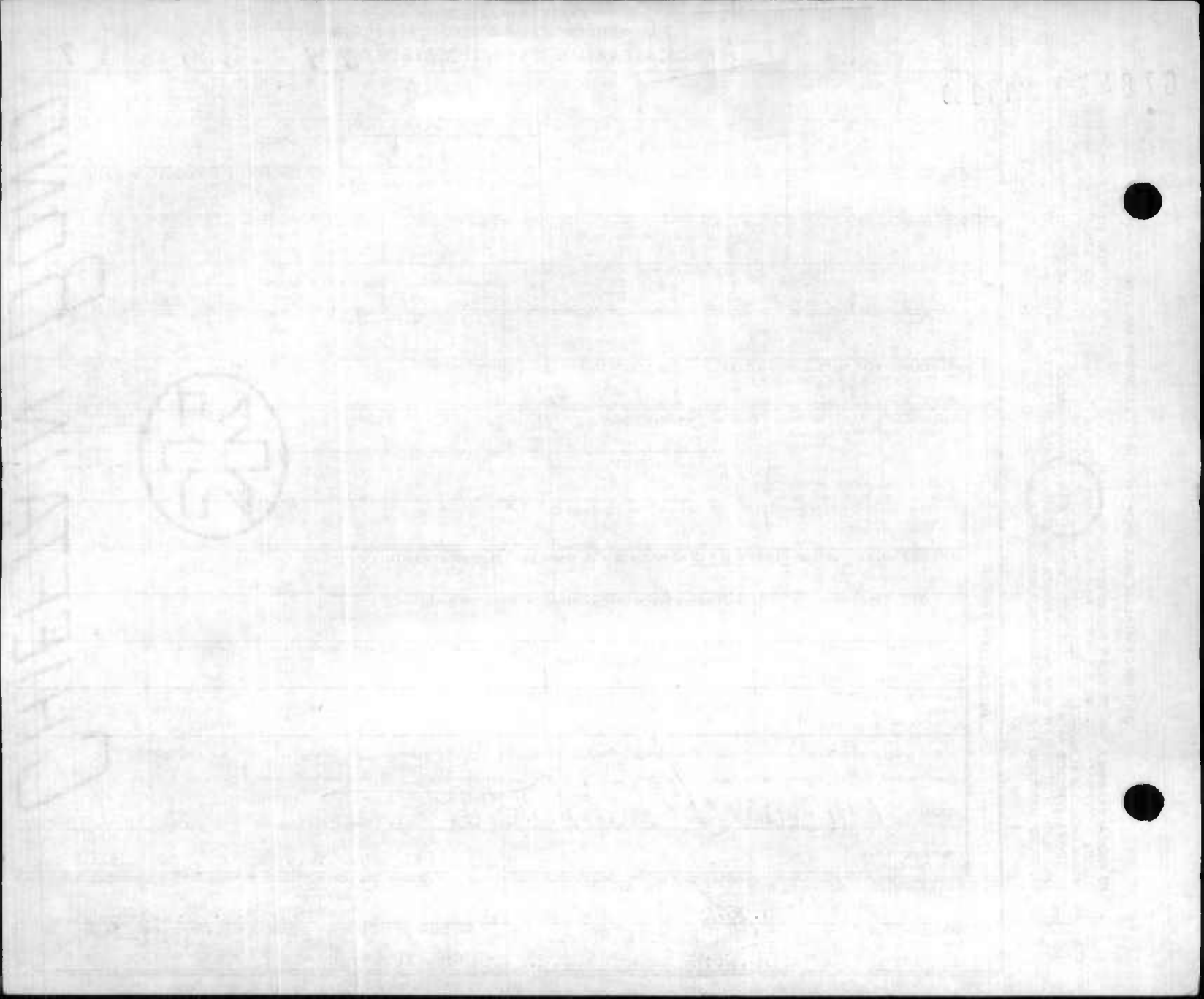
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR Unkn.#88-1 2-988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REC. NO. 36537									
1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST Barbara Marie Everett Dozier-					2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12/ 31/ 87			2b. HOUR M 17	
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR July 28, 1966	6 AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/ 31/ 87			2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			
10. CITY OR TOWN OF DEATH Landover		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7450 Landover Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Leon Everett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Dozier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-93-8422		17. INFORMANT ADDRESS 2330 Virginia Avenue, Apt. 303 Lucille Everett (mother) Landover, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COCAINE INTOXICATION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-29-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject used drugs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Found; 7450 Landover rd		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7450 Landover Rd PG. MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER				DATE SIGNED 1/1/88	
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 06, 1988		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland			
24. FUNERAL DIRECTOR NAME LATNEY'S FUNERAL HOME		ADDRESS 3831 Georgia Avenue, N.W.; Washington, D.C. 20011		25a. DATE REC'D. BY REGISTRAR JAN 14 1988		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

07/84
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(VR A15 ME (15))



077460 JAN - 7 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

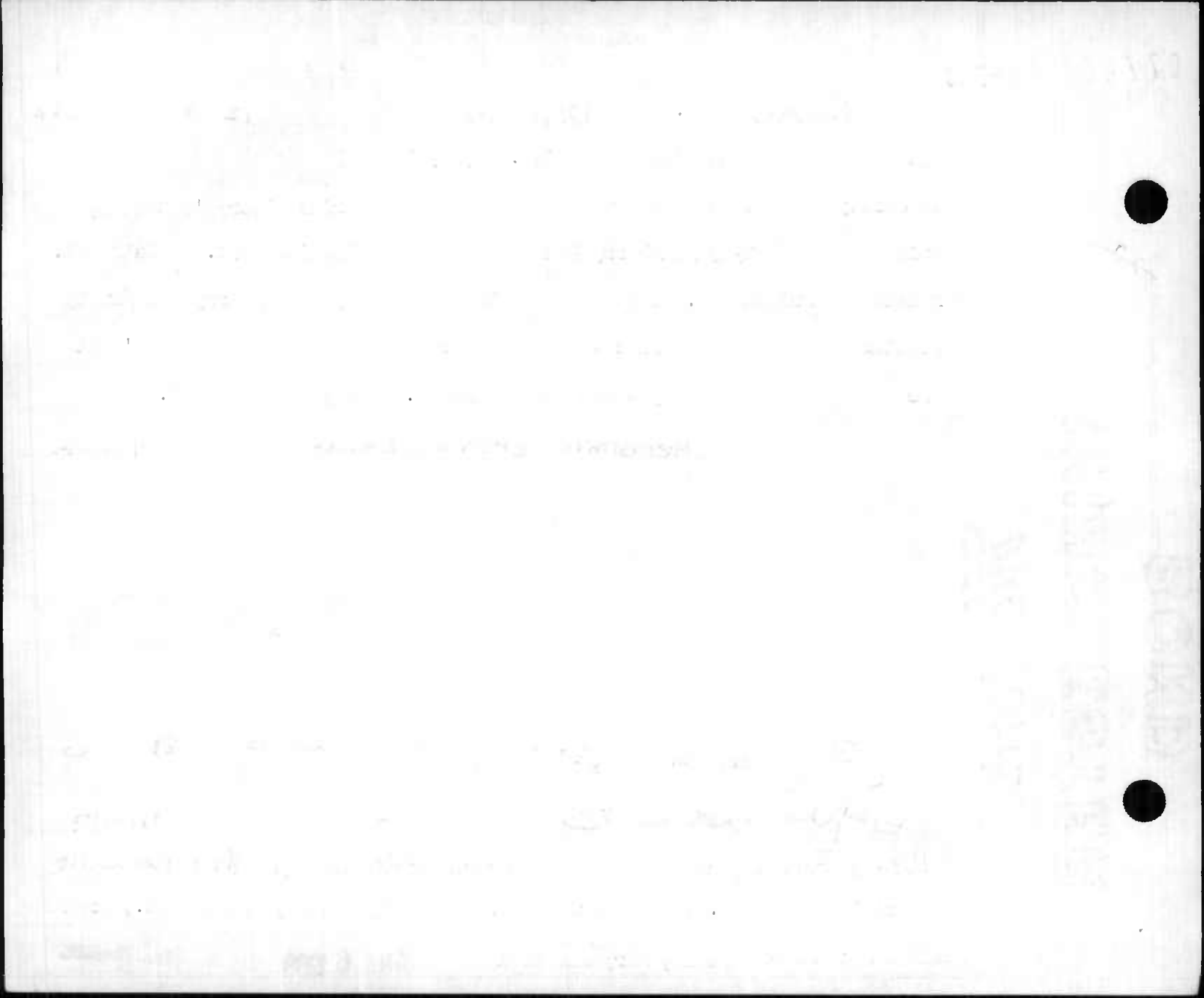
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 3 6 5 3 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nicholas E. Driscoll			2a. DATE OF DEATH MONTH DAY YEAR 12 30 87		2b. HOUR 0230AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD	
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2919 Blueberry Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Supt.		12b. KIND OF BUSINESS OR INDUSTRY Gulf Oil.	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2919 Blueberry Lane/20715		14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Driscoll		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah O'Neil			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 097-10-1600		17. INFORMANT ADDRESS Dolores D. Sharp, Same as # 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC GASTRIC Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from March , 19 87 , to Dec 30 , 19 87 , that (1) (we) last saw the deceased alive on Dec 21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) view the body after death.							
22b. SIGNATURE Ralph Bocca, MD				DEGREE MD		22c. DATE SIGNED 12/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Bocca, MD				22e. ADDRESS 14801 Physicians Ln #27 Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1988		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Prince Geo., Maryland	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR JAN 6 1988	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

MEDICAL CERTIFICATION

BP



075076 DEC 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36539

1. DECEASED NAME (TYPE OR PRINT) LILBURN LEROY DUGAN (A.K.A.) LEROY LILBURN DUGAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 7, 1987		2b. HOUR 3:25 a.m.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JAN. 25, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BRADFORD OAKS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MASTER SGT.		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S	13c. CITY OR TOWN ST. INIGOES	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CLINE DUGAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MAY SUTHERLAND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1962		17. INFORMANT BOX 7 ADDRESS YOSHIE DUGAN, ST. INIGOES, MARYLAND 20684	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> , 19 <u>87</u> , to <u>12-7</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12-6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>William Kent Furst</u> MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12787
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst, MD			22e. ADDRESS 11701 Livingston Rd. #101 Ft. Washington, Md. 20744		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-8-87	23c. NAME OF CEMETERY OR CREMATORY HUNTT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF, CHARLES, MARYLAND
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.			25a. DATE REC'D. BY REGISTRAR DEC 14 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP

DEC 14 1987

075306 DEC 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 1 3 6 5 4 0

1. DECEASED NAME (TYPE OR PRINT) Charles McGummskey Edmonston			2a. DATE OF DEATH MONTH December DAY 10 YEAR 1987		2b. HOUR 900 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH Sept. DAY 4 YEAR 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. of Am.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Upper Marlboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baileys Rest Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Major	
13a. STATE Maryland		13b. COUNTY P. Georges		13c. CITY OR TOWN Upper Marlboro	
14. FATHER'S NAME FIRST Walter MIDDLE Charles LAST Edmonston		15. MOTHER'S MAIDEN NAME FIRST ? MIDDLE ? LAST Yuouion		17. INFORMANT ADDRESS Mrs. M. A. Bailey (See 13c, above)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 224-16-6053		17. INFORMANT ADDRESS Mrs. M. A. Bailey (See 13c, above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure & Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart " 2 weeks DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of Lungs					
19a. DATE OF OPERATION Many Years Ago		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED " " "		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from Sept. 1979 to Dec. 10, 1987 , that (1) (the) last saw the deceased alive on Dec. 8, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walcutt W. Gibson MD DEGREE				22c. DATE SIGNED Dec. 10, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walcutt W. Gibson, M.D.				22e. ADDRESS 4300 St. Barnabas Road, Marlow Heights, Md. 20748	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/11/87		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Prince George's Md.		24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6683 Old Alexander Ferry Rd Clinton, Md 20735			
25a. DATE REC'D BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE A. B. Swindon-Randall			

10

M. C. [unclear]

Charles

Male

1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

11.2.1941

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11.2.1941

11.2.1941

11.2.1941

11.2.1941

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
THORNTON						EDWARDS		12		23		87		9		A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 74 HRS.		9. IF UNDER 74 HRS.		10. IF UNDER 74 HRS.		11. IF UNDER 74 HRS.	
MALE		NEGRO		8 12 97		29 YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH		12. BALTIMORE CITY OR COUNTY OF DEATH		13. BALTIMORE CITY OR COUNTY OF DEATH		14. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		PRINCE GEORGES COUNTY MD		PRINCE GEORGES COUNTY MD		PRINCE GEORGES COUNTY MD		PRINCE GEORGES COUNTY MD		PRINCE GEORGES COUNTY MD		PRINCE GEORGES COUNTY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. STREET ADDRESS / ZIP CODE		13c. STREET ADDRESS / ZIP CODE		13d. STREET ADDRESS / ZIP CODE		13e. STREET ADDRESS / ZIP CODE	
HYATTSVILLE		HYATTSVILLE MANOR NURSING HOME		INTERIOR DECORATOR		Self-employed		7604 NORMANDY ROAD 20785		7604 NORMANDY ROAD 20785		7604 NORMANDY ROAD 20785		7604 NORMANDY ROAD 20785		7604 NORMANDY ROAD 20785	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		17. INFORMANT ADDRESS		17. INFORMANT ADDRESS		17. INFORMANT ADDRESS		17. INFORMANT ADDRESS	
UNKNOWN		UNKNOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		577-14-7846		Landover, Md		Landover, Md		Landover, Md		Landover, Md		Landover, Md	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		19. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		20. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		21. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		22. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		23. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		24. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		25. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		26. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(b)		(b)		(b)		(b)		(b)		(b)		(b)		(b)		(b)	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
(c)		(c)		(c)		(c)		(c)		(c)		(c)		(c)		(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		19															
22a. I certify that (1) (this hospital) attended the deceased from 12/23/87 to 12/23/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (they) did not know the body after death.		22b. I certify that (1) (this hospital) attended the deceased from 12/23/87 to 12/23/87, and that (my) (our) opinion death occurred on the date and hour															

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15. 4)

007-102000



DEC 20 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36542

1. DECEASED NAME (TYPE OR PRINT) ESTHER J. EISERT		2a. DATE OF DEATH MONTH DAY YEAR December 13, 1987		2b. HOUR 8:55 P.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2 27 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing & Rehab Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Secretary		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.
13a. STATE N		13b. COUNTY	13c. CITY OR TOWN Washington D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Eisert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Fries			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-38-5279		17. INFORMANT ADDRESS Marie Distl same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>July 18</u> , 19 <u>87</u> , to <u>Dec. 13</u> , 19 <u>87</u> , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>87</u> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/>) (did not) view the body after death.					
22b. SIGNATURE <i>William Kent Furst</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst, M.D.		22e. ADDRESS 11701 Livingston Rd., Ft. Washington, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>	

2002-12-17

2002-12-17
2002-12-17
2002-12-17

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Monique Berthe Elliott		Female		white		September 30, 1927		60 YRS.		France		USA				Prince Georges MD.		housewife		home									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE																	
Laurel		910 White Way		Md		P.G.		Laurel				910 White Way 20707																	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS																			
Fernand Morel		Jeanne Antoinette Poyet		no		215 82 8569		George T. Elliott, Jr.		same as above																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>METASTATIC COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS</u> <u>2 YRS</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-																													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Robert D. Knight M.D.										22c. DATE SIGNED 17 DEC 87																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT D. KNIGHT										22e. ADDRESS Walter Reed AMC, Wash, D.C. 20307																			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE																							
Burial		Dec. 21, 1987		Md. Veterans Cemetery		Crownsville, Md																							
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home, Laurel, Md										25a. DATE REC'D. BY REGISTRAR DEC 23 1987										25b. REGISTRAR'S SIGNATURE Jillie Benson-Gadner									

076766 DEC 31 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36543

1871
8

RECEIVED

2000



076717 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Meyer M. Emanuel, Jr.					2a. DATE OF DEATH MONTH DAY YEAR 12-27-87					2b. HOUR 9-50P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Senator		12b. KIND OF BUSINESS OR INDUSTRY State Gov't.			
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10941 Tippet Rd.		20735	
14. FATHER'S NAME FIRST MIDDLE LAST Meyer M. Emanuel, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Cohen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 103-01-4501		17. INFORMANT Louise V. Emanuel as in item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypernephroma (metastatic)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic obstructive lung disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>12-27-87</u> to <u>12-27-87</u> , that (I) (the hospital) saw the deceased alive on <u>12-27-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>M. Koul</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/28/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Moti Koul M.D.				22e. ADDRESS 3710 Riviera St. Suite 2C Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-30-87		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.											

DEC 30 1987

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075474 DEC 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36545

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Rose Engelstad			2a. DATE OF DEATH MONTH DAY YEAR December 6, 1987		2b. HOUR 5:20 P_M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3102 Cheverly Avenue 20785		14. FATHER'S NAME FIRST MIDDLE LAST John Goheen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Rodrick		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 579-09-8278		17. INFORMANT Julian B. Engelstad		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> 19 <u>82</u> , to <u>12-6</u> 19 <u>87</u> , that (I) lost saw the deceased alive on <u>11-10</u> 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I did not) view the body after death.							
23. SIGNATURE Lawrence Z. Satin				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-8-87	
24. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE Z. SATIN MD				22e. ADDRESS 7500 Hanover Parkway, #103 Greenbelt, Md. 20770			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.				25a. DATE REC'D. BY REGISTRAR DEC 17 1987			
4739 Baltimore Avenue Hyattsville, Md. 20781				REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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ORIGINAL FILED

IMPERATIVE REPORT FAILURE

THANKS 2 SATIN MD

DEC 17 1963

076468 DEC 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36546
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CURTIS F ENNIS		2a. DATE OF DEATH MONTH DAY YEAR 12-25-87		2b. HOUR 6⁰⁵ A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1933	
6. AGE (IN YEARS LAST BIRTHDAY) 54		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hosp Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician - Ret	
12b. KIND OF BUSINESS OR INDUSTRY O.A.S.		13a. STREET ADDRESS / ZIP CODE 8102 Prince Georges Dr. 20744			
13b. STATE Maryland		13c. COUNTY Prince George		13d. CITY OR TOWN Ft. Washington	
14. FATHER'S NAME FIRST MIDDLE LAST William Bennie Ennis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Freeman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 237-44-9874		17. INFORMANT ADDRESS 8102 Prince Georges Dr. Norma Ennis Ft. Washington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST, CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CORONARY ARTERY DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION (ERRR) Plus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT 27 , 19 79 , to 12-25 , 19 87 , that (I) (most) lost saw the deceased alive on OCT 27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Danilo G. Lee		DEGREE MD		22c. DATE SIGNED 12-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANILLO G. LEE, MD		22e. ADDRESS 7700 OLD BRANCH AVENUE CLINTON, MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
23d. LOCATION CITY OR TOWN Clinton		COUNTY P.G.		STATE Maryland	
24. FUNERAL DIRECTOR NAME George P. kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25. DATE REC'D. BY REGISTRAR DEC 28 1987	
25. REGISTRAR'S SIGNATURE J. E. Rendon-Rendall					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed and signed by the attending physician or other qualified person within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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6 Pillsbury Rd. Ridgeview

074737 DEC 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 36547
2a DATE OF DEATH MONTH DAY YEAR 12 2 87 7 37 PM
2b HOUR
6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS
IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN
9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Virginia Enevoldson		2a DATE OF DEATH MONTH DAY YEAR 12 2 87 7 37 PM		2b HOUR
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 26, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager Real Estate agency	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Anne Arundel Lothian	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Dean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Candis Short		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 430 07 4889		17. INFORMANT ADDRESS 196 Waysons Mobile Ct. Lothian, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Pneumonia + Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Lungs MAY HAVE BEEN

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov 13</u> , 19 <u>87</u> , to <u>12-2</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE William Kent Jurek MD		22c. DATE SIGNED 12 2 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Jurek		22e. ADDRESS 11701 LIVINGSTON Rd #101 Ft WASHINGTON	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Shenandoah Page Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Bradley Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 10 1987	
ADDRESS Luray, Virginia		25b. REGISTRAR'S SIGNATURE John Anderson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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76878 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36548

1. DECEASED NAME (TYPE OR PRINT) Joseph A. ENGLISH			2a. DATE OF DEATH MONTH DAY YEAR 12 22 87		2b. HOUR 2:45 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 22 87		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE Maryland		13b. COUNTY P. G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Richard S. English		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Federici			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS 10616 Moores La. Richard English Clinton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MULTIPLE CONGESTIVE ANOMALIES</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PNEUMONIA, ABROPTED PLACENTA</u>					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	
22. I certify that (I) (this hospital) attended the deceased from <u>12/22, 1987</u> , to <u>12/22, 1987</u> , that (I) (we) lost saw the deceased alive on <u>12/22, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>St P. W.</u>		DEGREE MD		22c. DATE SIGNED 12/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven P. Winer		22e. ADDRESS Prince Georges Hill Court			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-87		23c. NAME OF CEMETERY OR CREMATORY Lakemont	
23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville AA Md.					
24. FUNERAL DIRECTOR NAME Lee Funeral Home		6633 Old Alexander Ferry Rd. Clinton, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1987	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36549

FOR 1. STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MARDY		RALPH		ERRERA		December 12, 1987		7:50 A.M.	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		MD	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of P.G. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Owner		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8501 Greenbelt Rd. #102 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Raphael		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Angel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2, Korean		17. INFORMANT ADDRESS Lisa D. Errera, Same as Line #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Cell Carcinoma of lung with Metastasis		DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. to liver, left kidney, Heart, hilar, Periaortic,		DUE TO, OR AS A CONSEQUENCE OF (c) Periaortic lymph nodes.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DEC 10 19 87, to DEC 12 19 87, that (I) (we) lost saw the deceased alive on DEC 12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE David M. Waitzman		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/12/87.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID M. WAITZMAN		22e. ADDRESS 8118 GOODLUCK ROAD, LANHAM, MD 20706							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G., Maryland			
24. FRANK CASCH'S SONS FUNERAL HOME, P.A. NAME ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 17 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0754 83 DEC 18 19

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]
6. [illegible]

7. [illegible]
8. [illegible]
9. [illegible]

DEC 17 1983

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) HARRY EVANS					2a. DATE OF DEATH MONTH DAY YEAR 12 28 87					2b. HOUR 6 05 P.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 05 10			6. AGE (IN YEARS LAST BIRTHDAY) 77			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Gov'T Employee Gov'T			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Capitol Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 708 Balboa Avenue 20743			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Evans					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-0901		17. INFORMANT ADDRESS B. Annis Whitfield Daughter Same as 13D.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Septic Left lower lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>dehydration</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>87</u> , to <u>12/28</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>12/28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DANIEL OBUTAS					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/29/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Obutas					22e. ADDRESS PG 6 H						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 05 Jan. 88		23c. NAME OF CEMETERY OR CREMATORY Harmony Park			23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland			
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home					25a. DATE REC'D. BY REGISTRAR JAN 6 1988			25b. REGISTRAR'S SIGNATURE Julia E. ...			

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

074974 DEC 15 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36551

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM H EVANS			2a. DATE OF DEATH MONTH DAY YEAR 12 01 87			2b. HOUR 11 15PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR March 30, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agriculture Economist		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Evans		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Hargis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					
16a. SOCIAL SECURITY NO. 217-44-0264		17. INFORMANT ADDRESS 4102 College Heights Drive Nelsa W. Evans Hyattsville, Md. 20782							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>overwhelming sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>bacteraemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Obstructive uropathy</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic obstructive lung disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <i>Nov.</i> 19 <i>85</i> , to <i>12-1</i> 19 <i>87</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>12-1</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>James Harding MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/2/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Scott Nelson</i>				22e. ADDRESS <i>Pocomoke City, Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/87		23c. NAME OF CEMETERY OR CREMATORY Pitts Creek Pres. Cam.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.			
24. FUNERAL DIRECTOR NAME <i>Scott Nelson</i>				ADDRESS <i>Pocomoke City, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 08 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1 PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6552	
1. FOR STATE REGISTRAR										2a. DATE KNOWN TO MONTH DAY YEAR	
DECEASED NAME (TYPE OR PRINT) <i>James Davis Ferguson</i>										2b. DATE OF DEATH MATED <input type="checkbox"/> 12-2-87	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7 13 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>12-2-87</i>		2d. HOUR <i>12:34</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i> MD.			
10. CITY OR TOWN OF DEATH <i>Cheverly</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supv. Supply</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Glen Arden</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7910 Dellwood Avenue</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Ferguson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susie Davis</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WW11 249084778</i>		17. INFORMANT <i>Marlene Ferguson</i>			ADDRESS <i>Glen Arden, Md. 7910 Dellwood Ave</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Renal failure</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>						TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>						ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>			DATE SIGNED <i>12-2-87</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/5/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland National</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel PG MD</i>			
24. FUNERAL DIRECTOR NAME <i>J. B. Jenkins</i>			ADDRESS <i>7474 Landover Road Landover, Md. 20785</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 07 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 36553

1. DECEASED NAME (TYPE OR PRINT)		FIRST DORI S		MIDDLE June		LAST FISCHER		2a. DATE OF DEATH			MONTH 12-28-87		DAY 8.14P		YEAR M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 5 YEAR 27				6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.											
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Aide			12b. KIND OF BUSINESS OR INDUSTRY Spring Dell								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland								13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18 Ell Lane / 20601					
14. FATHER'S NAME FIRST Thomas				MIDDLE		LAST Moore		15. MOTHER'S MAIDEN NAME FIRST Catherine								MIDDLE Schaumburg		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-94-1662		17. INFORMANT Mary A. Rawlings,				ADDRESS 3978 North Gate Pl Waldorf, Md. 20601									

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEIZURE DISORDER, POSSIBLE</u>	
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>LUNG CARCINOMA</u>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
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MEDIC	21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
	WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		STREET	CITY OR TOWN	COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-24-57, 19 , to 12-25-57, 19 , that (I) (we) last saw the deceased alive on 12-25-57, 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

72b SIGNATURE *Boyle H. Hatten* DEGREE *MD* ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 72c DATE SIGNED *12/29/87*

27a PHYSICIAN'S NAME (TYPE OR PRINT) KRISHAN MATHUR	27b ADDRESS Charles Prof. Center # 200 Waldorf Md. 20601
--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-30-87	23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	23d. LOCATION CITY OR TOWN Clinton	COUNTY P. G. Dade	STATE MD
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24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Arehart Funeral Home Inc. La Plata, Md. 20646				JAN 05 1988	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

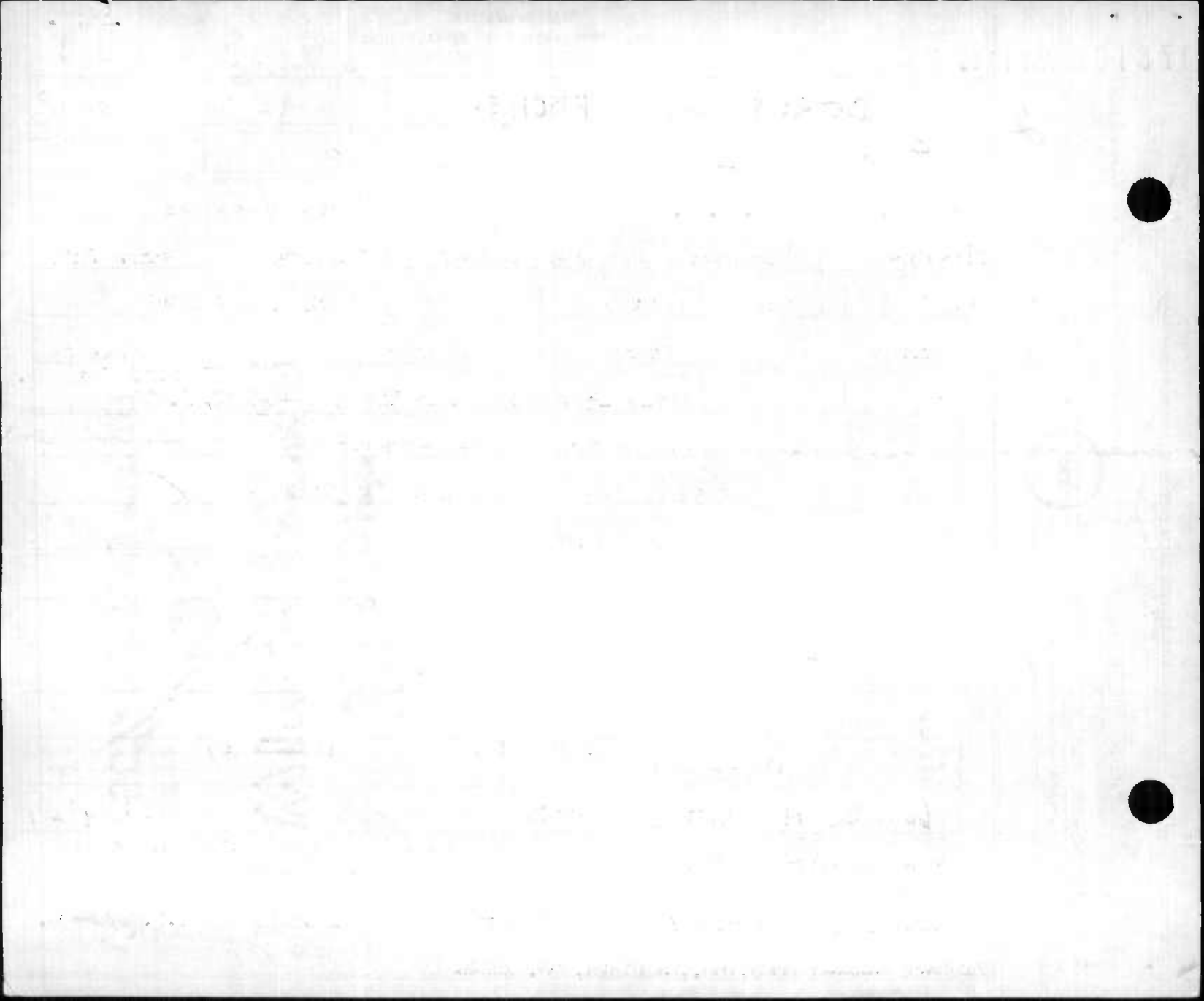
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified (if alive).

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



075587

DEC 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8738554
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: R. LAST: Follit			2a. DATE OF DEATH MONTH: December DAY: 11, YEAR: 1987		2b. HOUR 0950m
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH: OCT. DAY: 20, YEAR: 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH New Carrollton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7604 Riverdale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMPUTER OPERATOR	12b. KIND OF BUSINESS OR INDUSTRY GEOGRAPHIC
13a. STATE Md.		13b. COUNTY P.G.C.	13c. CITY OR TOWN NEW CARROLLTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: ROBERT MIDDLE: R. LAST: FOLLIT		15. MOTHER'S MAIDEN NAME FIRST: UNKNOWN MIDDLE: LAST:			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1940-1962	17. INFORMANT HELENE FOLLIT (SAME AS ITEM #13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1986</u> to <u>Nov 1987</u> , that (I) (we) lost <u>view of the deceased at 11:00 AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22a. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Becker, MD		22e. ADDRESS 14801 Parkview Ln #271 Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-17-1987	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM.		23d. LOCATION CITY OR TOWN: ARLINGTON, COUNTY: ARL. CO., STATE: VA.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR DEC 18 1987	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the field of occurrence must be certified as such.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36555

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	M
LOUISE				FRANCIS	11-19-87				6.55A	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Black	March 13, 1903			84	YRS		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD					
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d STREET ADDRESS / ZIP CODE					
13a STATE Maryland	13b COUNTY Pr. Georges	13c CITY OR TOWN Hyattsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5601 Parker House Terrace 20782						
14 FATHER'S NAME FIRST MIDDLE LAST Unknown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Williams		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						
16b SOCIAL SECURITY NO. 577-32-9845		17 INFORMANT ADDRESS Dolores Nicholls, 5125 Duel Pl. Capitol Heights Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ARDS vs Pulm. edema & Aspiration Pneumonia</u>										
19a DATE OF OPERATION 11-3-87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Cecal volvulus			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11-3-1987</u> to <u>11-19-1987</u> , that (I) (we) lost saw the deceased alive on <u>11-18-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>N S Dhalwal</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>11-19-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>NARINDER S. DHALIWAL</u>		22e. ADDRESS <u>Prince Georges General Hospital, Cheverly Md.</u>								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/23/87		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Georges, Maryland				
24 FUNERAL DIRECTOR NAME McGuire Funeral Service, 7400 Georgia Ave. N.W.		ADDRESS Washington, DC		25a DATE REC'D BY REGISTRAR DEC 22 1987		25b REGISTRAR'S SIGNATURE <u>Lia Davidson-Randall</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1. *CHINA*

Case 1:11-cv-00001 Document 1-1 Filed 01/26/12 Page 16 of 16

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1917

5115

... ..

DECEASED NAME
(TYPE OR PRINT)

2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
		12-31-87		7 : 30AM

HOURS	MIN.
1	15
2	30
3	45
4	00
5	15
6	30
7	45
8	00
9	15
10	30
11	45
12	00
13	15
14	30
15	45
16	00
17	15
18	30
19	45
20	00
21	15
22	30
23	45
24	00

9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Admin Asst (Ret)	School

22 Ridge Rd. #208 20770

MIDDLE LAST

Goldie Poe Wooden Laurel Md 20707

3.

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

IN CERTIFYING CAUSES OF DEATH?

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

211 LOCATION				
STREET	CITY OR TOWN	COUNTY	STATE	

27a. I certify that (I) (this hospital) attended the deceased from Dec 31, 1987, to Dec 31, 1987, that ~~we~~ (we) lost
saw the deceased alive on Dec 31, 1987, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated
above. ~~We~~ (we) (did) (~~do not~~) view the body after death.

27b. SIGNATURE <i>Samuel Fisher</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	27c. DATE SIGNED <i>12-31-87</i>
--	---------------------	--	-------------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
BARRY H. EPSTEIN MD	620 GREENBELT RD. COL PK, MD

23d LOCATION
7 **Laurel P.G.** COUNTY **Md.** STATE

24 FUNERAL DIRECTOR ^{NAME} Fleck ^{ADDRESS} 7601 Sandy Spring Rd. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DHMH - 16 60M 7/B4
(VRA 15. 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

1

075475 DEC 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36557
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Simon Edwin Fowler			2a. DATE OF DEATH MONTH DAY YEAR December 8, 1987		2b. HOUR MIN 10:00am
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 4, 1931		6 AGE (IN YEARS LAST BIRTHDAY) 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Landover		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4007 74th Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Grand Union		13. STREET ADDRESS / ZIP CODE 4007 74th Avenue 20784	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Landover	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Fowler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maurine Selig		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 579-36-0371		17. INFORMANT Virginia Fowler (Wife)		ADDRESS 4007 74th Avenue Landover, Md. 20784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>7 Dec 1987</u> to <u>7 Dec 1987</u> that (I) (we) last saw the deceased alive on <u>7 Dec 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22a. SIGNATURE <u>John J. [Signature]</u> MD				22b. DATE SIGNED <u>12-8-87</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN J. KEHOE</u>				22d. ADDRESS <u>6350 RIVERDALE AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION Brentwood P.G. Maryland		24. FRANCIS CASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781			
25. DATE REC'D. BY REGISTRAR DEC 17 1987				26. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>	

MEDICAL CERTIFICATION

289

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified on page 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet Eugenia FOWLER					2a. DATE OF DEATH MONTH DAY YEAR December 31, 1987					2b. HOUR 12:15AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD							
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR.GEO.CO								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3443 Elmley Avenue 21213							
14. FATHER'S NAME FIRST MIDDLE LAST Charles Francis McComas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Whilamina Holste				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 215-01-2020		17. INFORMANT Mrs. Betty May Wisniewski Owings, MD 20736	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Constructive Pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a organic Brain Syndrome															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12-26 19 87 , to 12-31 19 87 , that (I) (we) last saw the deceased alive on 12-31 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE R. Arora						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ARORA, M.D.						22e. ADDRESS 14300 Gallant Fox Lane #222 Bowie, Maryland 20715									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 01/04/1988		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 5 1988		25b. REGISTRAR'S SIGNATURE John S. ...							

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36559

1. DECEASED NAME (TYPE OR PRINT) John paul GIBBS, Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1987		2b. HOUR 2:20P M						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 19 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dairy Worker-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Embassy Dairy			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3528 Terrace Dr., Apt. A 20746			
14. FATHER'S NAME FIRST MIDDLE LAST William Gibbs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Pytt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-2058		17. INFORMANT ADDRESS 1914 Ritchie Rd. Laura Schroth Forestville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Liver cirrhosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Portal hypertension. Hypertension											
19a. DATE OF OPERATION 12/9/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhagic cholecystitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/8/87, 1987, to 12/12/87, 1987, that (I) (we) last saw the deceased alive on 12/12/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Maldonado				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/12/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Maldonado				22e. ADDRESS 9440 Marlboro Pike, Upper Marlboro, Md. 20772							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/87		23c. NAME OF CEMETERY OR CREMATORY Tracy Grove Bapt.Ch.Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hendersonville N.Car.					
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. ADDRESS Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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074321 DEC-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36560
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST CATHERINE J. GILBERT			MONTH DAY YEAR DECEMBER 1, 1987		3:13P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	Black	MONTH DAY YEAR 3 15 1906		81 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.			Prince George's MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham	Doctors Hospital of P. G.		Housewife		N/A	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland			P. Georges	S. Pleasant	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Nathaniel Jackson Martha Turner			FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	
No			212-16-438		7403 Crane Place Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senile Amyloid</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Old</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i> <i>year</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>CVA + Hypertension</i> <i>year</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>11-29-87</i> to <i>12-1-87</i> , that (I) (we) lost saw the deceased alive on <i>12-1-87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-1-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sahakian				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-5-87	Maryland National		Laurel P. G. Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. B. Jenkins		7474 Landover Road Landover, Md. 20785		DEC 07 1987 <i>Julia Gordon-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic evidence, a medical examiner must be notified at once.

BP

174331 DEC-83

1. The first part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

2. The second part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

3. The third part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

4. The fourth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

5. The fifth part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

6. The sixth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

7. The seventh part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

8. The eighth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

9. The ninth part of the report is a summary of the work done during the period covered by the report. It is a brief statement of the results of the work, and is intended to give a general impression of the progress made.

10. The tenth part of the report is a detailed account of the work done. It is a full and complete statement of the work, and is intended to give a detailed account of the progress made.

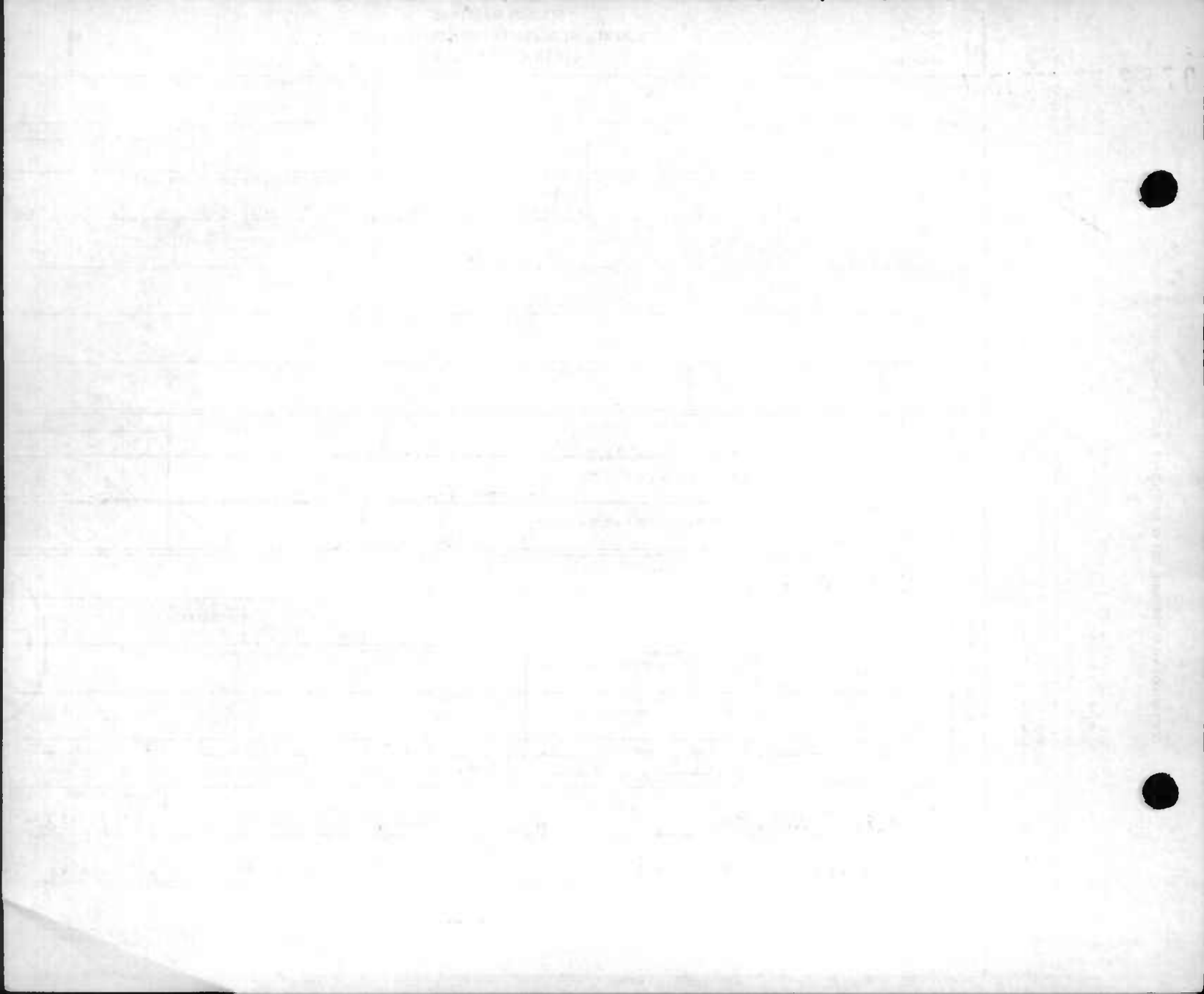
174331 DEC-83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		William Thomas Giles				December 13, 1987		2:00P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
male		white		Apr 21 1921		66		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wales, UK		USA				Prince Georges		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		AMI Doctors Hospital of Pr. Geo Co		Postal Clerk		US Gov't			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Calvert		Huntingtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3142 Soper Rd./20639	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Giles		Elizabeth White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
no		n/a		578 42 0572		Philip Giles (same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Circiac arrest		Acute Pulmonary Edema		Cory Artery Disease		1 hr.		1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
C.O.P.D. Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/14, 1987, to 12/13, 1987, that (I) (we) last saw the deceased alive on 12/13, 1987, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Stacy C Meshel		DEGREE MD		22c. DATE SIGNED 12/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Stacy C Meshel		5806 Baltimore Ave Hyattsville MD 20784							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12-16-87		Southern Mem. Gardens		Dunkirk Calvert MD			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rausch FH Owings, MD		20736		DEC 16 1987		Julia D. Jones			



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36562
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Perry Wilmer Gilroy, Jr.			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1987			2b. HOUR P M 3:07	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 19, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Perry Wilmer Gilroy, Sr.		15. MOTHER'S MAIDEN NAME Pauline M. Tippet		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11 214-03-4575	
17. INFORMANT Arvilla G. Gilroy same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD</u> DUE TO, OR AS A CONSEQUENCE OF <u>plus Prostatic Cancer & metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>plus Prostatic Cancer & metastases</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> , 19 <u>87</u> , to <u>12/29</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased die on <u>12/28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-30-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Stanley S. Josef, MD		22e. ADDRESS 4467 Old Branch Ave. Suite 201 Temple Hills, Maryland 20748					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 1, 1988		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pomonkey, Charles, Md.	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home		P.O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR DEC 31 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of case.

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James P. [unclear]
[unclear] [unclear]
[unclear] [unclear]

James P. [unclear]
[unclear] [unclear]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36563
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
BENJAMIN R. GIST JR.		Male		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
July 18, 1929		58 YRS		Maryland	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A.				Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Adelphi		Presidential Woods N.H.		Carpenter	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		P.G. Co.		Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Benjamin R. Gist Sr.		Bernadine - Lauer		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
579-36-1842		Mrs. Hazel Bell (Sister)		Same as # 13	
				Carcinoma of nose	
				DUE TO, OR AS A CONSEQUENCE OF	
				DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-23-87 1987 to 12-17 1987, that (I) (we) lay out the deceased alive or above, (I) (we) did not view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Myron L. Lenkin		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DEC. 17, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MYRON L. LENKIN, M.D.		2309 Shorefield Rd, Wheaton, Md 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/21/87		Ft. Lincoln Cemetery	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Brentwood P.G. Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
W.W. Chambers Co. Inc.		5801 Cleveland Riverdale Md. 20737		DEC 28 1987	
				24d. REGISTRAR'S SIGNATURE	
				[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36564

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERMA Cornelliuss GOLDRING			2a. DATE OF DEATH MONTH DAY YEAR 12 19 '87		2b. HOUR 7:35 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 1 1900	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES. MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN Md. Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Geo Clinton					
14. FATHER'S NAME FIRST MIDDLE LAST Ellis Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cassie Diggs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 38 3565	17. INFORMANT ADDRESS Box 371 Jos. Goldring Port Tobacco MD 20677			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mins 18 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Temporal Arteritis					
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, FURNISH MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (we) attended the deceased from Sept 8 , 19 68 , to Present , that (I) (we) last saw the deceased alive on Dec 19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur Shaver Jr. MD		DEGREE MD		22c. DATE SIGNED 12/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SHAVER JR. MD		22e. ADDRESS 9131 PISCATAWAY RD CLINTON MD. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/23/87	23c. NAME OF CEMETERY OR CREMATORY St Mary's Cath Ch		23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown, Chas., MD	
24. FUNERAL DIRECTOR NAME Marcell Adams, Aquasco Rd		ADDRESS 2060		25a. DATE REC'D. BY REGISTRAR DEC 24 1987	25b. REGISTRAR'S SIGNATURE John E. Anderson

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36565

1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DARLENE GOODRUM		2a DATE OF DEATH MONTH DAY YEAR 12 07 87		2b HOUR 2:40A	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 23 1965	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 22 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		12b KIND OF BUSINESS OR INDUSTRY Private			
13a STATE Maryland		13b COUNTY P. Georges		13c CITY OR TOWN P. Park	
14 FATHER'S NAME FIRST MIDDLE LAST James Goodrum		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maudie Brown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 215946366		17 INFORMANT James Goodrum	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Systemic Lupus Erythematosus</u>		<u>5 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>April 15</u> , 19 <u>87</u> , to <u>12/7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Jonathan Adelson MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/7/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. JONATHAN ADELSON		22e ADDRESS 7500 HANOVER PARKWAY #102 GREENBELT, MD 20770			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-11-87		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	
24 FUNERAL DIRECTOR NAME J. B. JENKINS		ADDRESS 7474 Landover Road Landover, Md. 20785		23d LOCATION CITY OR TOWN COUNTY STATE Landover P. G. Maryland	
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <u>John Anderson-Randall</u>		DEC - 9 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages 1, 2, 3, and 4 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

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075886 DEC 23 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36566

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			MONTH	DAY	YEAR	2b. HOUR
James Lornell Gordon						12-14-87			12	14	19	M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	Black	July 4, 1947	40s	MONTHS	DAYS	12-14			12	14	19	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCE XXX		9. BALTIMORE CITY OR COUNTY OF DEATH						
New York		USA				Prince Georges County			MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Upper Marlboro		10612 Mt. Lubentia Way				Police Officer						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		PG		Largo		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10612 Mt. Lubentia Way		20870		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
Robert Gordon				Louise Chambers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
yes				243 72 3652		Angelita Gordon-sister-						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of anterior chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30PM 12-14-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION CITY OR TOWN COUNTY STATE 10612 Mt. Lubentia Way, Upper Marlboro, Prince Georges County, MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER		DATE SIGNED 12-15-87		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Charles P. Kokes, M.D.				111 Penn Street, Baltimore, MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Dec. 18, 1987		Harmony Memorial Park			Landover, Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Stewart Funeral Home-4001 Benning Road, N.E.				DEC 22 1987								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

0525 10 338

21X

10/10/10

076478

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6567

1. DECEASED NAME

FIRST

MIDDLE

LAST

William E. Grant Jr.

2b. DATE KNOWN OF DEATH ESTI-
MATED ☒ MONTH DAY YEAR 12-16-87 2d HOUR M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

march 15, 1903

6. AGE (IN YEARS (LAST BIRTHDAY))

84 YRS.

IF UNDER 1 YR.

MONTHS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

12-16-87 8:33 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Florida

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH

CLINTON

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

NOT IN SUCH FACILITY, GIVE STREET ADDRESS
Southern Maryland Hospital Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Labor

12b. KIND OF BUSINESS OR INDUSTRY

Landscaper

13a. USUAL RESIDENCE (IF IN MARRIED HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Fla.

13b. CITY OR TOWN

Pinellas

13c. CITY OR TOWN

Dunedin

13d. INSIDE (CITY LIMITS)?

YES ☐ NO ☒

13e. STREET ADDRESS

1103 Douglas St.

14. FATHER'S NAME

William

MIDDLE

E.

LAST

Grant Sr.

15. MOTHER'S MAIDEN NAME

UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

375-03-2161

17. INFORMANT

Marilyn E. Morris Ft. Washington, Md. 20744

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

Diabetic hypertension arteriosclerotic vascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost

disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Chronic obstructive pulmonary disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

12-17-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

12-18-1987

23c. NAME OF CEMETERY OR CREMATORY

CHAMBERS CREMATORY

23d. LOCATION

RIVERDALE,

COUNTY

P.G.C. Md.

24. FUNERAL DIRECTOR

NAME

W. W. CHAMBERS CO. INC.

ADDRESS

RIVERDALE, Md. 20737

DATE REC'D BY REGISTRAR

DEC 28 1987

25b. REGISTRAR'S SIGNATURE

Linden-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (1))

07617 002041

100-10-1001 0001

U.S.A.

100-10-1001 0001

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100-10-1001 0001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 6 5 6 8
REG. NO.

076151 DEC 22 1987

FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST Eva	MIDDLE Amanda	LAST Graves	2a. DATE OF DEATH MONTH DAY YEAR 12 21 87		2b. HOUR 6:00 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 27, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Department Store				
13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5904 Center Drive 20748		
14. FATHER'S NAME FIRST MIDDLE LAST John Caleb Dean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Matilda Joy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 577-01-5546		17. INFORMANT Crandall D. Graves		ADDRESS Rte. 1 Box 408 Linden, VA 22642
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Common Duct obstruction - malignancy 2 mos</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> , 19 <u>73</u> , to <u>12-21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 12-21-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel M. Howell MD		22e. ADDRESS CHARLES PROCTER Box 20 WAPOO, 20694				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Grove St. Mary's Md.				
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12111100

12111100

12111100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36569

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
NELLIE GRAYSON					DEC. 2, 1987					8:00P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUCASIAN		FEB. 21, 1923		64		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASH. D.C.		U.S.A.				PRINCE GEORGES CO.				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
LANDOVER		7108 KENTTOWN DR.		HOUSEWIFE		AT HOME					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		P.G.C.		LANDOVER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7108 KENTTOWN DR.		20785	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
JOHN THEODORE WETZEL		NELLIE LOUISE CROSS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT							
NO		579-22-0037		MALCOLM K. GRAYSON		(SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - PULMONARY FAILURE</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF											1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											3 YRS
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
OSTEOPOROSIS OF SPINE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOV. 19 51, to 1 DEC. 19 87, that (I) (we) last saw the deceased alive on 1 DEC. 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
THOMAS HUTCHINS M. D.								12-2-1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
THOMAS HUTCHINS M. D.						6214 LANDOVER RD., CHEVERLY, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		12-4-1987		MARYLAND VETERANS CEM.		CHELTENHAM,		P.G.C.		Md.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS						DEC 09 1987		Julia Davidson-Randall			
W. W. CHAMBERS CO.						RIVERDALE, Md. 20737					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 REG. NO. 36570			
1. DECEASED NAME (Type or Print) PASQUALE J. GRAZIANO										2a. DATE OF DEATH MONTH DAY YEAR Dec 22, 1987		2b. HOUR 5:30 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 14 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G., MD.							
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY PEPCO					
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Berwyn Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6104 Quebec Place 20740					
14. FATHER'S NAME FIRST MIDDLE LAST CARMEN GRAZIANA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pasqualina Brizzi									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11 577-05-0414		17. INFORMANT 5920 Natasha Drive, Berwyn Heights, Md. Richard Graziano-son-									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1986 to Dec 22, 1987 , that (I) (we) last saw the deceased alive on 11/30/12-15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Gregory A. Compton M.D. DEGREE MD						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-22-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory A. Compton M.D.						22e. ADDRESS 8317 Cherry Lane Laurel, Md. 20707							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-24-1987		23c. NAME OF CEMETERY OR CREMATORY Maryland National		23d. LOCATION Laurel Pr. Georges Md.							
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md.						25a. DATE REC'D BY REGISTRAR (SLIP REGIS. NO. & SIGNATURE) DEC 28 1987 Julia Doherty-Rubner							

0163351-ETSM

074942 DEC 15 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36571
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Franklin</u> MIDDLE: <u>Albert</u> LAST: <u>Greer</u>			2a. DATE OF DEATH MONTH: <u>12</u> DAY: <u>5</u> YEAR: <u>87</u>		2b. HOUR <u>6.20 P.</u>		
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH: <u>11</u> DAY: <u>18</u> YEAR: <u>1924</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>64</u> YRS IF UNDER 1 YEAR: MONTHS: <u> </u> DAYS: <u> </u> IF UNDER 24 HRS: HOURS: <u> </u> MIN: <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGES</u> MD.	
10. CITY OR TOWN OF DEATH <u>CLINTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTHERN MARYLAND HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Data Processor</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>NASA</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Pr. Geo's</u>		13c. CITY OR TOWN <u>District Heights</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: <u>James</u> MIDDLE: <u>Arthur</u> LAST: <u>Greer</u>		15. MOTHER'S MAIDEN NAME FIRST: <u>Eda</u> MIDDLE: <u>Vivetta</u> LAST: <u>Wetzel</u>		13e. STREET ADDRESS / ZIP CODE <u>5805 Marlboro Pike, Apt. #201/</u>		20747	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WWII</u>		17. INFORMANT <u>Franklin Albert Greer</u>		ADDRESS <u>5805 Marlboro Pike, Apt. #201, District Heights, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic ca. lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>87</u> , to <u>12/5</u> , 19 <u>87</u> , that (I) (we) lost above, the deceased alive on <u>12/5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <u>Cyrus V. Parsey M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/7/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CYRUS V. PARSEY M.D.</u>				22e. ADDRESS <u>8700 Old Branch Ave Clinton MD 20735</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/9/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Leeland (Pr. Geo's) Md.</u>	
24. FUNERAL DIRECTOR <u>Richard A. Coleman, Upper Marlboro, Md. 20772</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 14 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 7 3 6 5 7 2

1 - FOR
STATE
REGISTRAR

DECEASED NAME (FULL OR PRINT) HARRY Charles GUICE		7a. DATE OF DEATH MONTH DAY YEAR 12-27-87		7b. HOUR 9.45A M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 18, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Decorating

13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Capitol Heights	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4216 Rail Street 20743
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14. FATHER'S NAME FIRST MIDDLE LAST William T. Guice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie F. Thompson	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II	17. INFORMANT ADDRESS 4216 Rail Street Capitol Heights, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20743
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Renal Failure</u>	
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>87</u> , to <u>12-27</u> , 19 <u>87</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12-27</u> , 19 <u>87</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>(we)</u> did not view the body after death.)	
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22b. SIGNATURE <u>Louis Steinberg</u> M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Louis Steinberg</u>	22e. ADDRESS <u>6492 Landover Rd, Landover Rd</u>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/30/87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
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24. FUNERAL HOME OR OTHER PLACE WHERE FUNERAL SERVICES WERE HELD NAME ADDRESS Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	25a. DATE REC'D. BY REGISTRAR JAN 5 1988	25b. REGISTRAR'S SIGNATURE <u>Jane Davidson</u>
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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36573

1. DECEASED NAME (TYPE OR PRINT) ROBERT		FIRST MIDDLE LAST HAGLER		2a. DATE OF DEATH MONTH DAY YEAR 11 / 13 / 87		2b. HOUR 11:55 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JUNE 20 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G. MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINISTER		12b. KIND OF BUSINESS OR INDUSTRY SELF	
13a. STATE M.D.		13b. COUNTY P.G.		13c. CITY OR TOWN CAPITOL HTS.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 715 61st AVE 20743		14. FATHER'S NAME FIRST MIDDLE LAST ROBERT HANGLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LENOIRE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 223-12-4041 A		17. INFORMANT ADDRESS ELIZABERT HAGLER 715 61st AVE 20743		17. INFORMANT CITY OR TOWN STATE CAPITOL HTS. MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROGRESSIVE MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) EARLY SMALL BOWEL OBSTRUCTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from February 11/13 1987 to November 1987 , that (1) (we) lost saw the deceased alive on above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Boccia		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAUL BOCCIA, MD		22e. ADDRESS 14801 PHYSICIANS LN #271 Rockville					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-21-87		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G. MARYLAND	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a. DATE REC'D. BY REGISTRAR JAN 12 1988		25b. REGISTRAR'S SIGNATURE Lia E. ...	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23 MAY 1951

3

1. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

2. The second part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

3. The third part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The fourth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

4. The fourth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The fifth part is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HP
DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36574

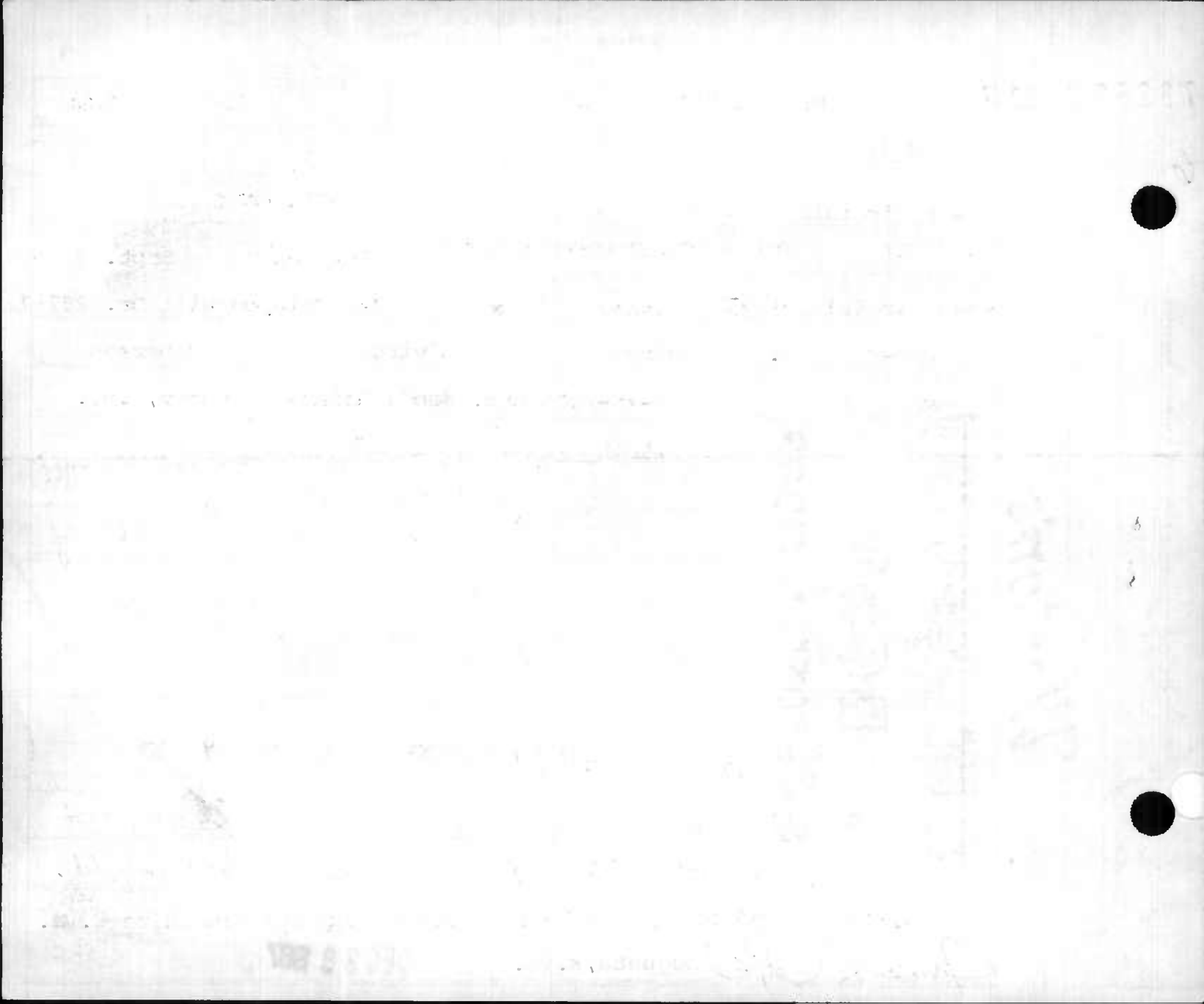
1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST H. KERMIT HAINES			2a. DATE OF DEATH MONTH DAY YEAR 12-19-87		2b. HOUR 2.00A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 22 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector	12b. KIND OF BUSINESS OR INDUSTRY Dept. labor	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN West Virginia Hampshire Romney			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 222 Whippoorwill Dr. 26757
14. FATHER'S NAME FIRST MIDDLE LAST James A. Haines		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvirda Roberson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 236-28-2089	17. INFORMANT ADDRESS Mrs. Wanda Haines Romney, W. Va.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease, coronary artery disease		50 days
DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory failure, COPD		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: aorto-iliac occlusive disease					
19a. DATE OF OPERATION 11/2/87 / 12/19/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aorto-iliac occlusive disease / ventilation dependent	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18/87 to 12/19/87, that (I) (we) last saw the deceased alive on 12/18/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Atul N. Jani, MD		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATUL N. JANI, MD		22e. ADDRESS Prince George's Hospital Center, Chesapeake, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/22/87	23c. NAME OF CEMETERY OR CREMATORY Malick Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Augusta Hampshire N. Va.
24. FUNERAL DIRECTOR NAME James R. Gyles		ADDRESS Augusta, W. Va.	25a. DATE REC'D. BY REGISTRAR DEC 28 1987
		25b. REGISTRAR'S SIGNATURE	



075468 DEC 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36575

1. DECEASED NAME (TYPE OR PRINT) William Tracy Hale Sr.		2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 87		2b. HOUR 11A M.
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH 03 DAY 10 YEAR 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing/Rehabilitation		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer(R)	
13a. STATE Virginia		13b. COUNTY Prince Wm.	13c. CITY OR TOWN Dumfries	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Edward MIDDLE S. LAST Hale		15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE NMI LAST Rogers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea/V.N. 164-18-1939		17. INFORMANT Evelyn Hale Dumfries, Va. 22026

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Immed		APPROXIMATE INTERVAL BETWEEN CHIEF AND DEATH
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: G.I. Bleeding, Severe End Stage Alzheimer Disease			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in item 16, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 4/9 85 to 12/13 87 that (1) (we) last saw the deceased alive on 12/13/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) saw the body after death.			
22b. SIGNATURE Kelvin L. Minchin		DEGREE MD	22c. DATE SIGNED 12/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KELVIN L. MINCHIN		22e. ADDRESS 6188 OXON HILL RD OXON HILL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/16/87	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia
24. FUNERAL DIRECTOR Bea		25a. DATE REC'D. BY REGISTRAR DEC 17 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36576

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMA B Haliday			2a. DATE OF DEATH MONTH DAY YEAR 12/25/87		2b. HOUR 1:08 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 24, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Aquasco, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Maryland			13b. COUNTY Pr George	13c. CITY OR TOWN Parkland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Cleveland Canter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Belle Gibbons		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-24-9885	17. INFORMANT ADDRESS Malcolm Haliday 6824 Walker Mill Rd Capitol Hts, MD #202		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COLD DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASND Atrial tachycardia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 12-25 , 19 87 , to 12-25 , 19 87 , that (1) (we) lost saw the deceased alive on 12-25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.					
22b. SIGNATURE William Kent Furst			DEGREE MD	22c. DATE SIGNED 12 26 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM KENT FURST, MD.			22e. ADDRESS 11701 LIVINGSTON ROAD #101 FORT WASHINGTON, MD. 20744		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec 28, 1987	23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland MD	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm			25a. DATE REC'D. BY REGISTRAR DEC 29 1987		
ADDRESS Funeral Home Suitland, Md			25b. REGISTRAR'S SIGNATURE J. E. Burden-Henderson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1912-1913

John J. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3736577
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helene (NMI) HAMMERSCHMIDT			2a. DATE OF DEATH MONTH DAY YEAR 12 24 1987		2b. HOUR 6:50A M
3 SEX Female	4 RACE CAUCASSIAN	5. DATE OF BIRTH MONTH DAY YEAR April 3, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b CITIZEN OF WHAT COUNTRY? Germany	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Nolte		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmine Schneider		13e. STREET ADDRESS / ZIP CODE 2702 Filbert Lane 20715	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-58-9869		17 INFORMANT ADDRESS Helga Angeli same as 13e	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) DUE TO, OR AS A CONSEQUENCE OF		
(c) DUE TO, OR AS A CONSEQUENCE OF		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/18/87, to 12/24/87 that (I) (we) last saw the deceased alive on 12/23/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Sood		DEGREE M.D.		22c. DATE SIGNED 12/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Sood		22e. ADDRESS 6911 Laurel Bowie Rd., Bowie, Md. 20715			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec. 24, 1987	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	23d. LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME Beall Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 30 1987	
25b. REGISTRAR'S SIGNATURE Julia B. [Signature]		25c. REGISTRAR'S SIGNATURE	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

 BP
 DHMH - 16 50M 4/83
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a. DATE OF DEATH Dec. 25 1987			2b. TIME OF DEATH 10:30 P		REG. NO. 87 36573		
3. DECEASED NAME (TYPE OR PRINT) MAURICE J HAMPTON		4. SEX Male		5. RACE White		6. DATE OF BIRTH MO 08 DA 14 YE 08		7. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			
10. CITY OR TOWN OF DEATH LARGO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY WG & L			
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 6504 Lacona Street 20735	
14. FATHER'S NAME John W. Hampton		15. MOTHER'S MAIDEN NAME Lillian E. Redmiles		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-05-3828		17. INFORMANT ADDRESS Gloria Hampton 6504 Lacona St. Forestville MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> <u>10 years</u> <u>8 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/31</u> , 19 <u>77</u> , to <u>12/25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Leonard P. Appel</u>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD P. APPEL		22f. ADDRESS 3231 Superior Lane Bowie Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 28 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION Sutland PG MD			
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		24b. ADDRESS Sutland MD		25a. DATE REC'D. BY REGISTRAR DEC 29 1987		25b. REGISTRAR'S SIGNATURE <u>John E. Eiden-Rodale</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 00579

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT C HANNA		2a. DATE OF DEATH MONTH DAY YEAR DEC 5 '87		2b. HOUR MIN. 9:50 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 / 31 / 27	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 60	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD	
13a. STATE Maryland		13b. COUNTY PR GEORGE		13c. CITY OR TOWN CLINTON	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HENRY HANNA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ELLEN RIGGLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW1		16b. SOCIAL SECURITY NO. 579-34-0747		17. INFORMANT Elinore Hanna	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchiopneumonia Hepatic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Oak cell Carcinoma of lung with DUE TO, OR AS A CONSEQUENCE OF (c) metastasis to liver and lymph nodes		18b. SOCIAL SECURITY NO. 579-34-0747		18c. ADDRESS 1815 Independence Ave SE SOUTHEAST WASH DC	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/30 19 87 to 12/5 19 87 , that (b) (we) last saw the deceased alive on 12/5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE R. GINDE MD		DEGREE Pathologist		22c. DATE SIGNED Dec 7 '87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. GINDE		22e. ADDRESS Southern Md Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10 DEC 1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR NAME ROBERT E WILHELM FUNERAL HOME		ADDRESS SUITLAND MD.		25a. DATE REC'D BY REGISTRAR DEC 14 1987	
25b. REGISTRAR'S SIGNATURE					

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REG. NO. 26580

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) JERRY		MIDDLE HARDY		LAST HARDY		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 11/21 19 87		2b. DATE OF DEATH MONTH DAY YEAR 11/21 19 87		2c. DATE OF DEATH MONTH DAY YEAR 11/21 19 87	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9/17/52		6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.		7. IF UNDER 1 YR. MONTHS DAYS 0 0		7. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Metro Trackman		12b. KIND OF BUSINESS OR INDUSTRY W.M.T.A.			
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Capt. Hts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1709 Dewitt Ave. 20743			
14. FATHER'S NAME FIRST MIDDLE LAST James Hardy, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Siler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-70-1024		17. INFORMANT ADDRESS Louise S. Hardy 1709 Dewitt Ave. Capt. Hts., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Septicemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Neisseria meningitidis (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Esophageal varices, ascites, ethylism, substance abuse, pancytopenia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER Amended certificate issued		DATE SIGNED 11/27/1987					
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/25/87		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Rollins F.H., Inc 4339 Hunt Pl., N.E. Wash. D.C. 20019				25a. DATE REC'D. BY REGISTRAR 01 1987		25b. REGISTRAR'S SIGNATURE [Signature]					

07/84
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DHMH - 17

(VR A15 ME (5))

DHMH - 17

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Dr. P. Joseph
released 7/20/98

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				Medical Examiner - 87 REG. NO. 36581-K	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis. Ralph HARDY			2a. DATE OF DEATH MONTH DAY YEAR 12-12-87		2b. HOUR 3:20 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 11, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Analyst		12b. KIND OF BUSINESS OR INDUSTRY Library of Congress
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gilbert Hardy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Mack			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 215-26-3187		17. INFORMANT (Wife) ADDRESS Blanche G. Hardy 5805 42nd Avenue Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RUPTURED AORTIC ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-11-87 to 12-12-87, that (I) (we) lost the deceased above on 12-12-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE K. JOSEPH MATHEN		DEGREE MD		22c. DATE SIGNED 12/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 6516 Kenilworth Ave Riverdale, MD 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/16/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood P.G. Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Maryland		25a. DATE REC'D. BY REGISTRAR DEC 17 1987			
25b. REGISTRAR'S SIGNATURE John Swickard-Rodell					

2. FUNERAL HOME FOR

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue Hyattsville, Md. 20781

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

DEC 17 1970

10/10/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36582

1. FOR
STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LENA

K.

HARE

20. DATE OF DEATH

MONTH

DAY

YEAR

26. HOUR

12-14-87

10:20 PM

3. SEX

Female

4. RACE

CAUC.

5. DATE OF BIRTH

MONTH

DAY

YEAR

7-15-98

6. AGE (IN YEARS LAST BIRTHDAY)

89

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington DC

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

10. CITY OR TOWN OF DEATH

Clinton, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

BRADFORD OAKS

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Saleslady

12b. KIND OF BUSINESS OR INDUSTRY

Retail Dept

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

PG.

13c. CITY OR TOWN

Suitland

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

2404 Porter Ave 20746

14. FATHER'S NAME

SAMUEL

MIDDLE

LAST

MADDOX

15. MOTHER'S MAIDEN NAME

ELIZABETH

MIDDLE

LAST

FAIRALL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

578-36-4565

17. INFORMANT

John E Bibb

ADDRESS

Newburg, MD

Rt #1 Box 991

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) ASHD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 726, 1987, to 1217, 1987, that (I) (we) lost
saw the deceased alive on 126, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

William Kent Furst

DEGREE

MD

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

12/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

William K. Furst M.D.

22e. ADDRESS

11701 Livingston Rd Ft Washington Maryland

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

18Dec1987

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery Suitland

COUNTY

PG

STATE

Md

24. FUNERAL DIRECTOR'S NAME
Robert E Wilhelm
Funeral Home

ADDRESS

Suitland, Md

25a. DATE REC'D. BY REGISTRAR

DEC 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Swinson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper in space provided and return it to the funeral home with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

705230 9 27 05

DEC 31 1997

076385

DEC 28 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36583

2a DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
EARL		HARMEL, SR.						12		18	87	6 20PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Dec. 3, 1931		56		MONTHS		DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U. S. A.				PRINCE GEORGES COUNTY						MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
CHEVERLY		PRINCE GEORGES HOSPITAL CENTER		Grain Farmer		Own Farm							
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE					
Maryland		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 123-J., Route 382/20601					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Henry		Harmel, Sr.		Roberta		McKenzie							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT									
No				Patricia J. Harmel-		Box 123-J., Route 382, Waldorf, Md. 20601							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <i>Cardio myopathy</i>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Coronary Heart Failure, Renal Failure, Liver Failure</i>			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f LOCATION			
STREET		CITY OR TOWN COUNTY STATE	

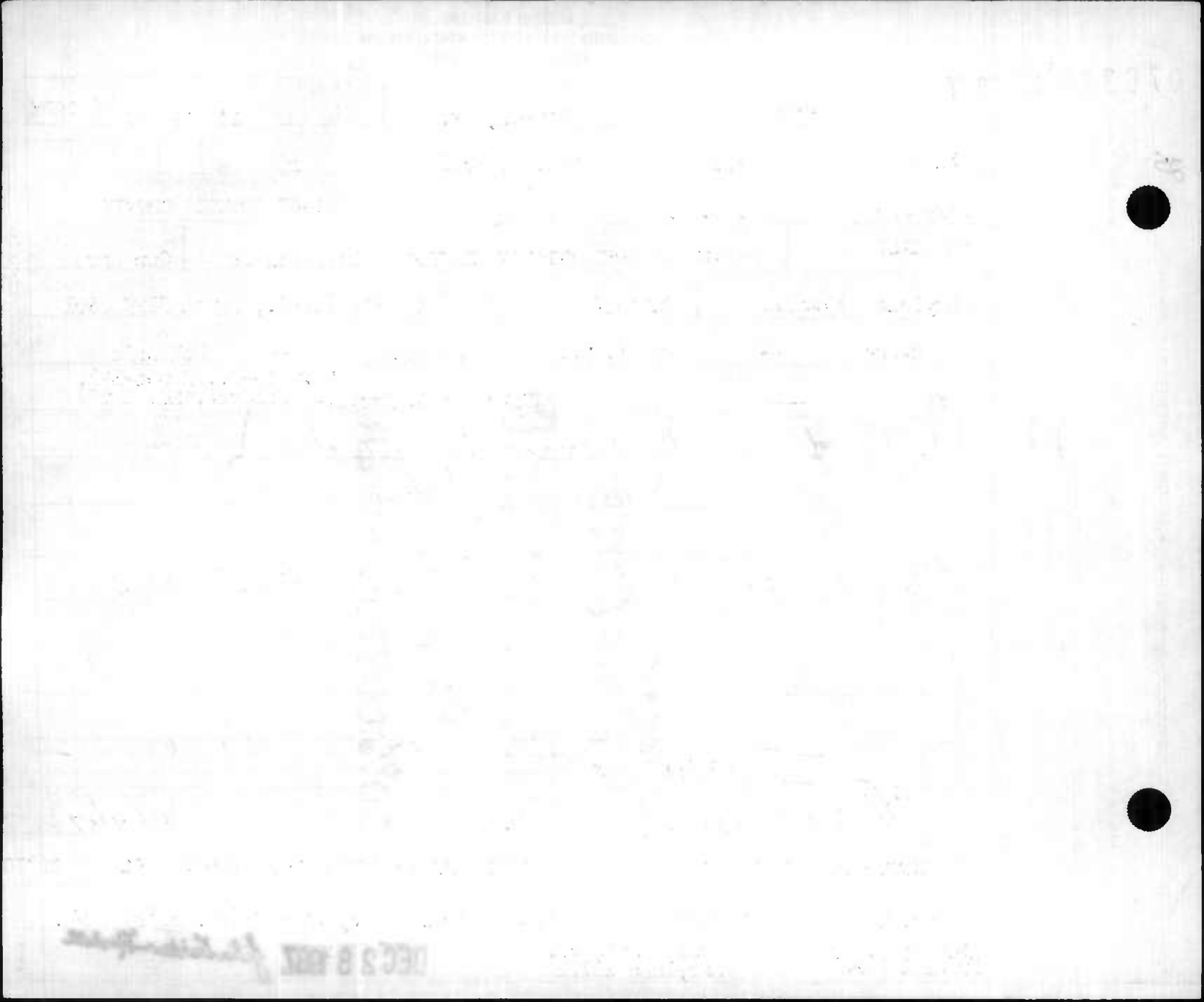
22a I certify that (I) (this hospital) attended the deceased from		19 <i>04</i> to <i>14/18</i> 19 <i>87</i> , that (I) (was) lost	
saw the deceased alive on <i>12/18</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE		DEGREE	
<i>Clarke A. Holmes, M.D.</i>		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS	
CLARKE A. HOLMES, MD		14314 OLD MARLBORO PIKE, UPPER MARL. MD 20870	
22f DATE SIGNED			
<i>12/19/87</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial		12/22/87		Fort Lincoln Cem.		Brentwood (Pr. Geo's) Md.	
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REG. NO.			
Richard A. Coleman		DEC 28 1987					
Funeral Home		Upper Marlboro, Maryland 20772					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

075930

FOR
STATE
REGISTRAR

87 REG. NO. 36584

1. DECEASED NAME (TYPE OR PRINT)		FIRST Mabel		MIDDLE A.		LAST HARMON		2a. DATE OF DEATH MONTH DAY YEAR December 15, 1987		2b. HOUR 3:50 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing Home	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Gunn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Dunbar		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 225-16-9554		17. INFORMANT Marion M. Harmon (Daughter)		ADDRESS 51 S. Bruce Street Laurel, Md 20707	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain hemorrhage</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> , 19 <u>87</u> , to <u>12/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Aleem A. Iqbal</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEEM A. IQBAL		22e. ADDRESS 7525 Greenway CTR DR. Greenbelt, Md 20768									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/87		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY Alexandria Virginia					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		25a. DATE REC'D BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0700 10 24 2307

9030 20 1000 2307

9030 20 1000 2307

9030 20 1000 2307

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077209

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36585

1. DECEASED NAME (a) OR PRINT) Alma			2a. DATE OF DEATH MONTH 12 DAY 30 YEAR 87			2b. HOUR 8:50 A.M.					
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH 08 DAY 17 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't employee		12b. KIND OF BUSINESS OR INDUSTRY ARDC			
13a. STATE MD			13b. COUNTY P.G.		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2118 Jameson St., 20748		
14. FATHER'S NAME FIRST Lester MIDDLE W. LAST Harris				15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE L. LAST Friedrich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579-14-6764		17. INFORMANT ADDRESS Mary Withers 2115 Iverson St., 20748						
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD - UTI -											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 87 , to 12/30 , 19 87 , that (I) (we) lost saw the deceased alive on 12/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. M. ...						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/30/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEZ A MOSTAN						22e. ADDRESS 4235 26th Ave NW 20748					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-2-88		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD				
24. FUNERAL DIRECTOR NAME Wilhelm Funeral Home ADDRESS #65						25a. DATE REC'D. BY REGISTRAR JAN 5 1988					

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JAN 5 1988

20. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 21. HOUR OF ESTI. MATED ☐ 12/14 87

2c. DATE MONTH DAY YEAR 2d. HOUR
PRONOUNCED 12:30
DEAD 12/14 87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's County</i>
--	---	---	---

10. CITY OR TOWN OF DEATH Brentwood	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3814 - 38th Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
--	--	---	--

USUAL RESIDENCE (if in nursing home or other institution, give residence before admission)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3814 - 38th Street 20222
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Brentwood		

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Fred		Traugbner	Estelle		Chism

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)	17. INFORMANT (NAME AND ADDRESS)
No	N/A	6520 Westview Lane F. Earl Williams Lanham, Md. 20706
217-44-2967		

10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	<u>Chronic obstructive pulmonary disease.</u>	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under- lying cause last.</u>	{ DUE TO, OR AS A CONSEQUENCE OF	
	(b) _____	
	{ DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
None		

21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

27a I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12/15/87

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road
Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN)	COUNTY	STATE
Burial	12-18-87	Glenwood Cemetery	Washington,	D.C.	

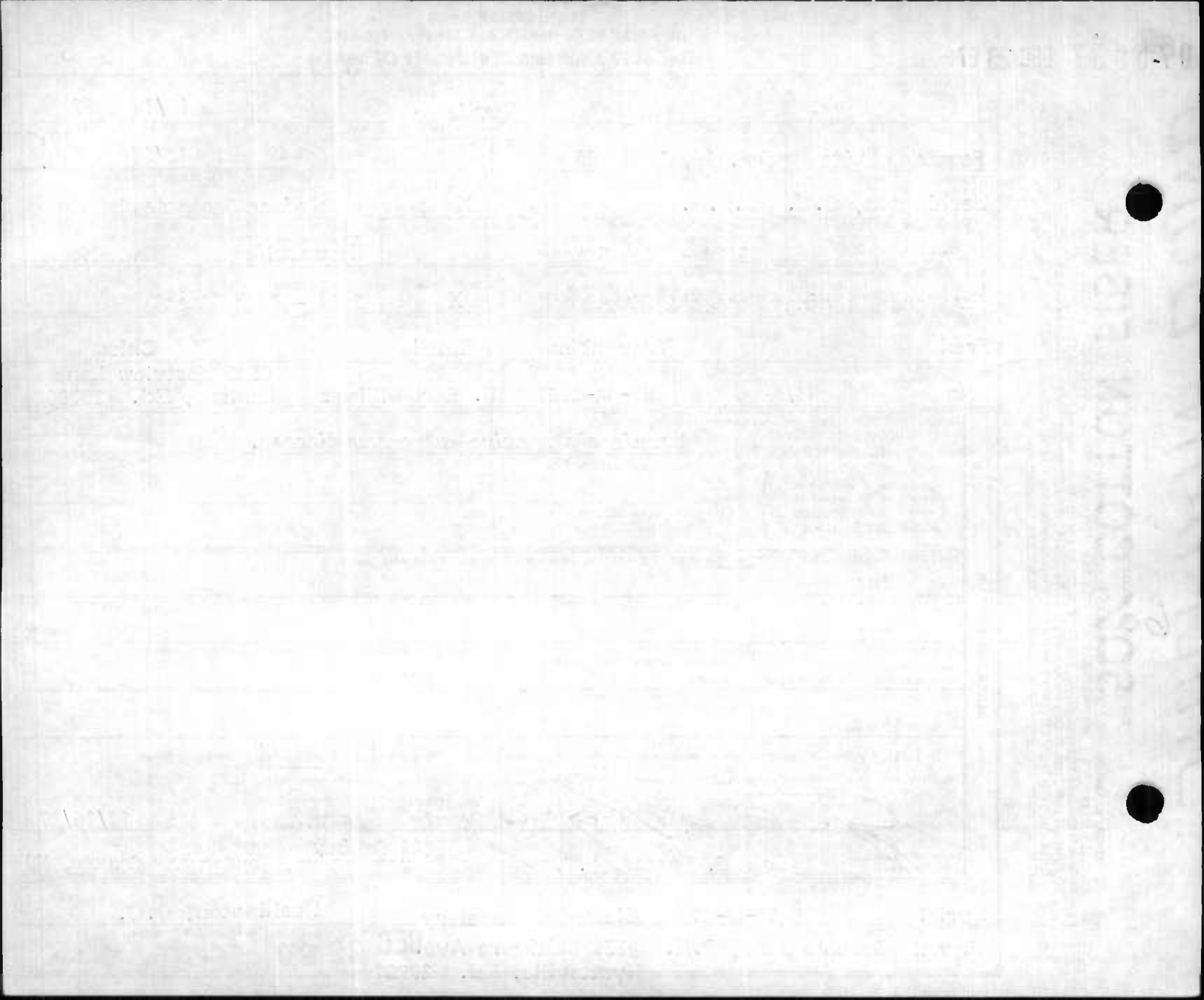
24. FUNERAL DIRECTOR Francis Gasch's Sons, P.A. 4739 Baltimore Ave Hyattsville, Md. 20781	25a. DATE REC'D. BY REGISTRAR DEC 22 1987	25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall
--	--	---

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP _____
25M
DHMH - 17
(VR A15 ME (5))



076795 DEC 31

187 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36587

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William John Hartmeyer, Sr			2a. DATE OF DEATH MONTH DAY YEAR December 14, 1987		2b. HOUR M M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR September 30, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 90		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7200 Contee Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sales manager		12b. KIND OF BUSINESS OR INDUSTRY mineral pigment corp.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD PG Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7200 Contee Road 20707				
14. FATHER'S NAME FIRST MIDDLE LAST William John Hartmeyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Hoeckel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 041 09 2463		17. INFORMANT ADDRESS Ida Fischer 10131 Washington Blvd Laurel, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dec 14 1987					
22a. I certify that (I) (this hospital) attended the deceased from Dec 5 1987 to Dec 14 1987 , that (I) (we) lost saw the deceased alive on Dec 5 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert C. Wingfield		DEGREE Med		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 15 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Wingfield		22e. ADDRESS Secund. Maryland							
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE Dec. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md			
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home, Laurel, Md						25a. DATE REC'D. BY REGISTRAR DEC 21 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rodriguez	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-100-100

RECEIVED
FEB 10 1964

100-100-100



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6588

FOR per med exam

1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Herbert

Hawkins

3 SEX

Male

4 RACE

Black

5. DATE OF BIRTH

Jan. 9, 1909

6. AGE (IN YEARS)

78

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN

7a. DATE KNOWN
OF DEATHMONTH DAY YEAR
11 29 877b. HOUR
M
9:127c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
11 29 877d. HOUR
M
9:127a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Kansas

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County MD

10 CITY OR TOWN OF DEATH

Laurel

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greater Laurel/Beltsville Hospital12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

20707

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Pr. Geo.

13c. CITY OR TOWN

Laurel

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

Stable Area Laurel Race Course

14. FATHER'S NAME
FIRST

Unknown

15. MOTHER'S MAIDEN NAME
FIRST

Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

347-12-6895

17. INFORMANT

Dan Seamans

ADDRESS
6314 Windsor Mill Rd.
Baltimore, MD 2120718 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

DIABETES MELLITUS

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinionACTUAL
SIGNATURE*Mario F. Golle, Jr.*

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE
SIGNED. 11/30/87EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS

111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12-10-87

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Cemetery

23d. LOCATION
CITY OR TOWN

Baltimore, Maryland

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

George R. Snowden

ADDRESS

Rockville, MD 20850

25a. DATE REC'D. BY REGISTRAR

DEC 14 1987

25b. REGISTRAR'S SIGNATURE

*John D. Anderson*TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

038031-03515



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6589

075931 DEC 23 1987

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH		
GEORGE Lee HAZEL, JR.			12 16 19 87			12 16 19 87			12 16 19 87			9:20 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		
Male	White	Oct. 8, 1987	0 YRS.	2 MONTHS	0 HRS.	Prince George's County			Riverdale			5813 63rd Ave.		
12. BIRTHPLACE (STATE OR COUNTY)			13. CITIZEN OF WHAT COUNTRY?			14. MARRIED			15. NEVER MARRIED			16. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.			WIDOWED			NEVER MARRIED			Prince George's County		
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. STATE			19. COUNTY			20. CITY OR TOWN			21. STREET ADDRESS		
Maryland			Prince George's			Riverdale			5813 63rd Avenue			20737		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. SOCIAL SECURITY NO.			18. INFORMANT		
George Lee			Kathern Hazel, Sr.			No			None			Mary Carter (Grandmother) Riverdale, Md.		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21. EXTERNAL CAUSE WAS			22. TIME OF INJURY		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. MONTH DAY YEAR		
23. INJURY OCCURRED			24. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			25. LOCATION			26. I certify that I took charge of the remains described above, held on			27. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE			death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) Deputy Chief		
28. ACTUAL SIGNATURE			29. EXAMINER'S NAME (TYPE OR PRINT)			30. ADDRESS			31. DATE SIGNED			32. DATE REC'D. BY REGISTRAR		
Ann M. Dixon, M.D.			111 Penn St., Balto., MD 21201			12-16-87			DEC 22 1987			33. REGISTRAR'S SIGNATURE		
34. BURIAL, CREMATION, REMOVAL (SPECIFY)			35. DATE			36. NAME OF CEMETERY OR CREMATORY			37. LOCATION CITY OR TOWN			38. COUNTY STATE		
Burial			12/19/87			Ft. Lincoln Cemetery			Brentwood			P.G. Maryland		
39. FUNERAL DIRECTOR'S NAME			40. ADDRESS			41. DATE REC'D. BY REGISTRAR			42. REGISTRAR'S SIGNATURE			43. DATE REC'D. BY REGISTRAR		
Francis Gasch's Sons Funeral Home, P.A.			4739 Baltimore Avenue Hyattsville, Md. 20781			DEC 22 1987			J. A. Gordon-Rodriguez			DEC 22 1987		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

056031 103101

ДЛЯ

МЛТЭЛН

РЕГИСТРОМ



075299 DEC 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 3 6 5 9 0

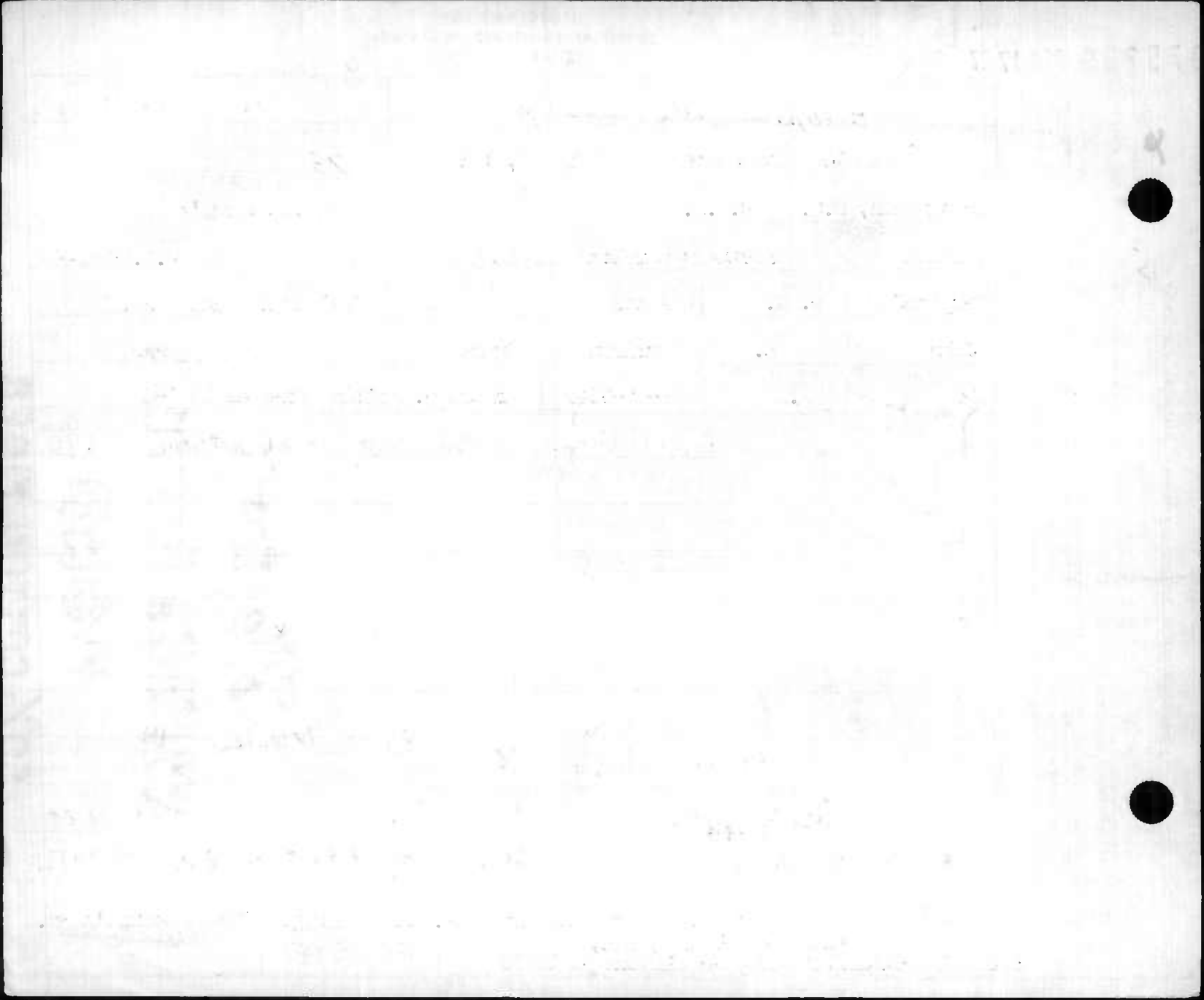
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Evelyn M Heflin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-13-87</i>		2b. HOUR <i>2:30 p.m.</i>	
3. SEX <i>F Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 11, 1914</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD.		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P. G.</i>		13c. CITY OR TOWN <i>Clinton</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John B. Morrison</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Grace Harmon</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-09-3549</i>		17. INFORMANT ADDRESS <i>Robert H. Heflin Same as 13 A-E</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchio alveolar cell carcinoma with bone metastasis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>January</i> 19 <i>81</i> , to <i>December</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>12-12</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <i>wash the body after death.</i>						
22b. SIGNATURE <i>Kai-Yun YOUNG, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12-13-87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kai-Yun YOUNG, M.D.</i>		22e. ADDRESS <i>8926 Woodyard Rd #201 Clinton, MD 20735</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/16/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l. Cem</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Prince George's Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 16 1987</i>				
24. FUNERAL DIRECTOR NAME <i>Lee Funeral Home, Inc.</i> ADDRESS <i>63 Old Alexander Ferry Rd Clinton Md 20735</i>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



074199 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36591

FOR STATE REGISTRAR		1- DECEASED NAME FIRST MIDDLE LAST EDNA LEE HENSON		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 19 87 12		2b. HOUR 15 M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Nov 22 1921		6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CLEO L THOMAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED ZONOBIA INLOWE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 553-24-0273	
17. INFORMANT HAROLD T HENSON/8044 CENTRAL PK DR (22309)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <u>[Signature]</u>		TITLE (SPECIFY) M.D. <u>Boyer</u>		MEDICAL EXAMINER		DATE SIGNED <u>Dec 1, 1987</u>	
EXAMINER'S NAME (TYPE OR PRINT) _____		ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/ 5/87		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, DC	
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA 22314		ADDRESS _____		25a. DATE REC'D. BY REGISTRAR DEC - 4 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

05-100 DEC-70

2028 COLONY FIELD

2028 COLONY FIELD

2028 COLONY FIELD



075583 DEC 21

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36592

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH DAY YEAR		4. HOUR MIN	
5. DECEASED NAME (TYPE OR PRINT)		6. FIRST		7. MIDDLE		8. LAST	
9. SEX		10. RACE		11. DATE OF BIRTH MONTH DAY YEAR		12. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14. CITIZEN OF WHAT COUNTRY?		15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		16. BALTIMORE CITY OR COUNTY OF DEATH	
17. CITY OR TOWN OF DEATH		18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		20. KIND OF BUSINESS OR INDUSTRY	
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		22. STATE		23. CITY OR TOWN		24. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
25. FATHER'S NAME FIRST MIDDLE LAST		26. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		27. ADDRESS		28. DATE OF DEATH	
29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		30. SOCIAL SECURITY NO.		31. INFORMANT		32. ADDRESS	
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		34. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		35. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		36. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
37. DATE OF OPERATION		38. CONDITION FOR WHICH OPERATION WAS PERFORMED?		39. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
41. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		42. TIME OF INJURY P.M. 19		43. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		44. LOCATION STREET CITY OR TOWN COUNTY STATE	
45. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		46. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		47. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		48. ACTUAL SIGNATURE	
49. EXAMINER'S NAME (TYPE OR PRINT)		50. ADDRESS		51. TITLE (SPECIFY)		52. MEDICAL EXAMINER	
53. BURIAL, CREMATION, REMOVAL (SPECIFY)		54. DATE		55. NAME OF CEMETERY OR CREMATORY		56. LOCATION CITY OR TOWN COUNTY STATE	
57. FUNERAL DIRECTOR NAME		58. ADDRESS		59. DATE REC'D. BY REGISTRAR		60. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 (RETAIN PAGE 5 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25MBP
DHMH - 17
(VR A15 ME (5))

Burial

12-17-1987

George Washington Cemetery Adelphi P.G. Maryland

Donald Borgwardt

4400 Powder Mill Road
Beltsville, MD. 20705

DEC 18 1987

J. H. Gordon

073-303-214

CONFIDENTIAL

SECRET

NO TOP SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

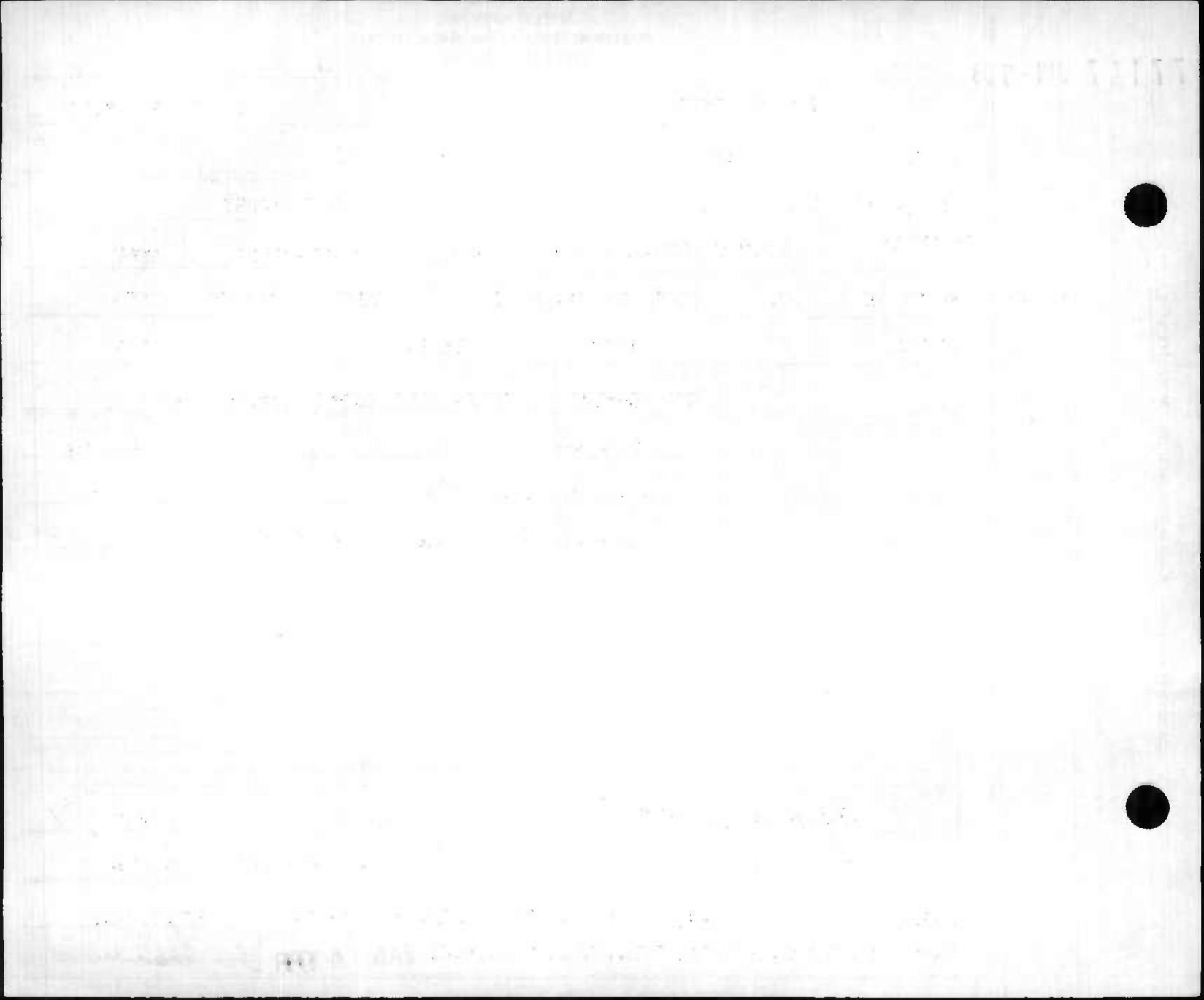
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8736593

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MILBERT HINTON		2a. DATE OF DEATH MONTH DAY YEAR 12-27-87		2b. HOUR 2.20P M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN SEAT PLEASANT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY HINTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA WREN		11. STREET ADDRESS / ZIP CODE 7200 "G" STREET 20743			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-05-6125		17. INFORMANT ADDRESS VIVIAN PYE (FRIEND) SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Multiple Decubiti</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Alzheimer's Disease.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks - 1 yr yrs -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. Berard</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERARD		22e. ADDRESS 7100 Baltimore Ave 401 College Park Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-31-87		23c. NAME OF CEMETERY OR CREMATORY EASTER BAPT. CHURCH CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WAVERLY, VA.	
24. FUNERAL DIRECTOR VANN & WILLIAMS, 4804 GA. AVE., N.W., WASH., D.C.				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE <i>John T. Anderson</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

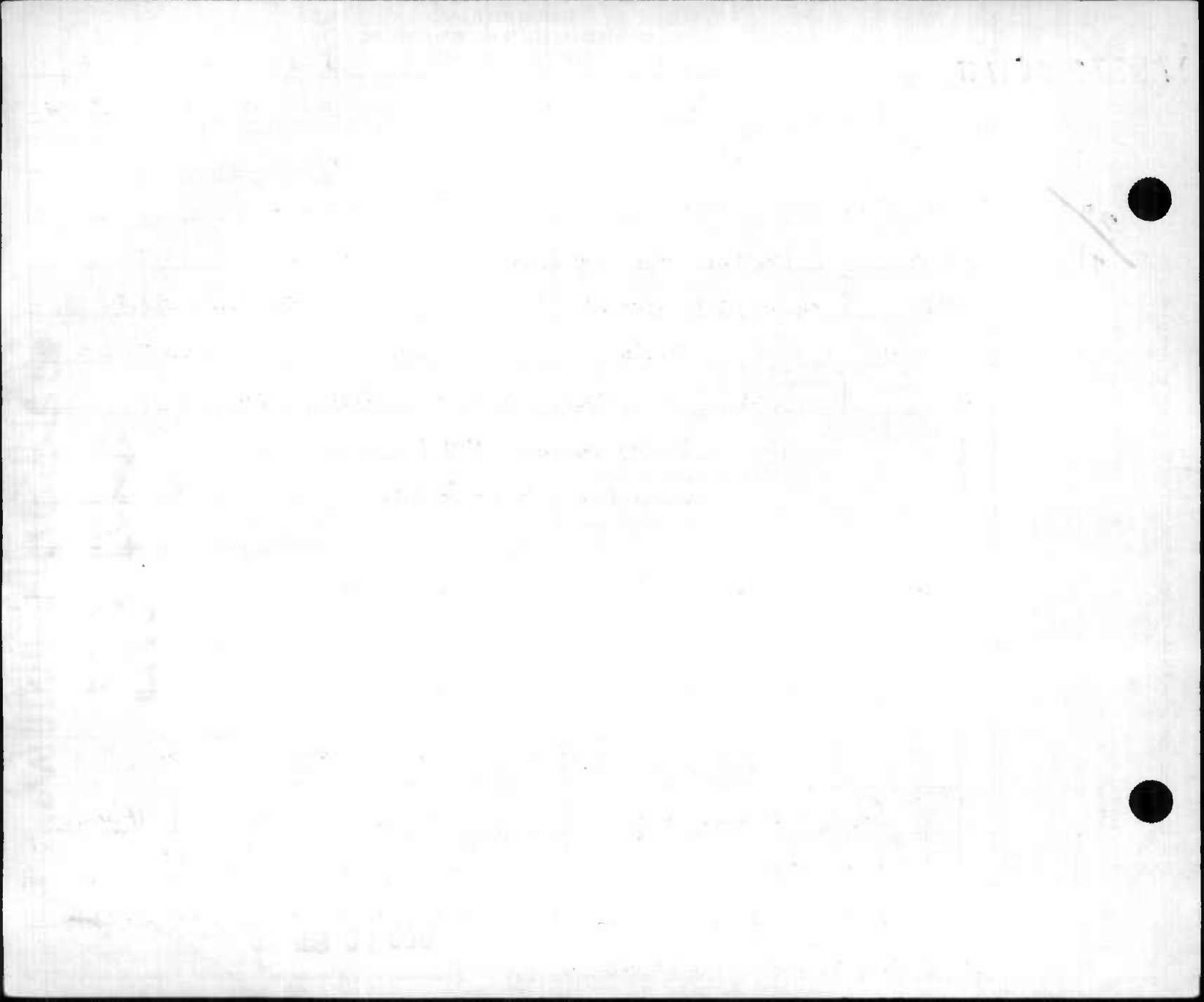
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36594

1. DECEASED NAME (TYPE OR PRINT)		FIRST Andrew		MIDDLE L.		LAST HISLER		2a. DATE OF DEATH MONTH DAY YEAR 12 13 87		2b. HOUR 7:50A M	
3 SEX M		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 14 47		6 AGE (IN YEARS, LAST BIRTHDAY) 90 YRS		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY CIVIL					
13a. STATE Md		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 125 BRALAN LANE 20877			
14. FATHER'S NAME FIRST MIDDLE LAST ANDRE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA GRENTZINGER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1917-1919		17 INFORMANT 577-09-3333		ADDRESS ARLINE WICKER/DAUGHTER/SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dehydration Anemia Syncope History of CVA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>DEC 6</u> , 19 <u>87</u> , to <u>DEC 13</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>DEC 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Oswald Lawrence Hays</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>97 Dec 13</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oswald L Hays		22e. ADDRESS 9131 Greataway Rd Clinton Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 16, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		24b. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901									
24c. DATE RECEIVED BY REGISTRAR DEC 16 1987		24d. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION



075251 DEC 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH36595
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis Minivh Hoffman				2a. DATE KNOWN OF DEATH ESTIMATED Dec 9 1987				2b. HOUR P			
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH Sept DAY 28 YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Dec-10 1987				2d. HOUR A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2007 Beechwood Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETAIL CLOTHING STORE		12b. IND OF BUSINESS OR INDUSTRY OWNER			
13a. STATE MD				13b. COUNTY Prince Georges		13c. CITY OR TOWN Lewisdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2078 Beechwood Rd	
14. FATHER'S NAME FIRST RICHARD MIDDLE MINISH LAST MINISH				15. MOTHER'S MAIDEN NAME FIRST ROSA MIDDLE THOMPSON LAST THOMPSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 246-01-0743		17. INFORMANT ADDRESS ROSALIE KATZ, GAITHERSBURG MD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
TITLE (SPECIFY) M.D. Dep MEDICAL EXAMINER					
ACTUAL SIGNATURE J. B. S. Rogers				DATE SIGNED Dec 10, 1987	
EXAMINER'S NAME (TYPE OR PRINT) J. B. S. Rogers ADDRESS _____					

23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Dec 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Jonesville Cemetery		23d. LOCATION CITY OR TOWN Jonesville COUNTY Stafford STATE Virginia	
24. FUNERAL DIRECTOR NAME Takome Funeral Home ADDRESS 254 Canal St NW DC				25. DATE RECEIVED BY REGISTRAR DEC 15 1987		26. REGISTRAR'S SIGNATURE J. B. S. Rogers	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTEN STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRISTEN ST., BALTIMORE, MD, 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



RECEIVED
DEC 10 1971

Handwritten text, possibly a name or address, written vertically in a cursive or slanted script. It is difficult to decipher due to the handwriting and fading.

Handwritten text at the bottom of the page, including what appears to be a date "DEC 10 1971" and some illegible signatures or names.

173977 DEC-3

Items 18a, 21b.-22a., by Med. Ex. G-634

STATE 12/21/87, Gbj.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30590

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Allen Darnell Holland			MONTH DAY YEAR 11-25 19 87			M a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		
Male	Black	MONTH DAY YEAR April 10 1952	LAST BIRTHDAY) 35 YRS.	MONTHS DAYS	HOURS MIN.	MONTH DAY YEAR 11-25 19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA			Prince George's County, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Suitland			4710 Medora Drive			Engineer		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Maryland			Prince George		Suitland		4710 Medora Drive 20746	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT		
FIRST MIDDLE LAST Wardell Holland			FIRST MIDDLE LAST Evelyn Jones			ADDRESS 4710 Medora Drive Suitland, Md		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
(YES, NO, OR UNKNOWN) No			(IF YES, GIVE WAR OR DATES)			Leona Holland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Narcotic intoxication</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) <u></u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u></u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 11 25 1987		Subject used drugs			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			home		4710 Medora Dr., Suitland Prince George's, Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			Deputy Chief			11-25-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			Nov. 30-87		St. Edmonds Chr. Cem.		Sunderland Calvert Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Spencer E. Sewell			1451 Dares Beach Rd. Prince Frederick, Md			DEC 03 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-200. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

9984
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DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 30597	
1- STATE REGISTRAR		2a. DECEASED NAME (PRINT) FIRST MIDDLE LAST <i>Blease Hollands</i>						2b. DATE KNOWN OF DEATH MONTH DAY YEAR <i>12-19 1987</i>		2c. HOUR <i>507</i>	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 31, 1918</i>	6. AGE (IN YEARS) MONTHS DAYS <i>69 YRS.</i>	IF UNDER 1 YR. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>12-19 1987</i>		7d. HOUR <i>507</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Morningside</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Malcomb Grove Hospital (AAFB)</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Councilor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Nursing Home</i>			
13a. STATE <i>Wash., D. C.</i>				13b. COUNTY <i>---</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1362 Randolph St., NW 9999</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur Hollands</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sudie Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>1942 to 1944</i>		243 01 4310		17. INFORMANT ADDRESS <i>Queen Askew-Sister, NW, Washington, D.C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arteriosclerotic Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Diabetic leg amputation, edema</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>12-20-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez MD</i>				ADDRESS <i>5209 Bayburn Ct. Gp. Spr. Prince Md 20748</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 23, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>W.W. Chambers, 517 11th St., SE, Wash., D.C.</i>				25a. DATE RECD. BY REGISTRAR <i>DEC 28 1987</i>				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)075933 DEC 23 87
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36598
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia Wheeler HOLTZMAN			2a. DATE OF DEATH MONTH DAY YEAR December 15 1987		2b. HOUR P 9:00 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08-23-1918		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 69		
10. CITY OR TOWN OF DEATH W. Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2311 Sheridan Street		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME FIRST MIDDLE LAST John C. Steinberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Disney		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-14-3288		17. INFORMANT ADDRESS William Holtzman Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of brain DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lungs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two months Unknown Unknown						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 25 June 1973 to 15 December 1987 , that (I) (we) lost saw the deceased alive on 15 December 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. Medical examiner notified						
22b. SIGNATURE <i>Carl J. Houmann</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 16 Dec. 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M. D.		22e. ADDRESS 4404 Queensbury Rd. Riverdale, MD 20737				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville, Howard, Md.		23e. DATE REC'D. BY REGISTRAR DEC 22 1987				
24. FRANCIS CASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>				

BP

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your machine. I will try to get it fixed as soon as possible.

I am, Sir, very respectfully,
Yours truly,
J. H. Smith

076635 DEC 31 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36599

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR			
		Thomas		T.		Houston				12/		20/19		87				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
MALE		WHITE		MAY 25, 1923		64 YRS.						12/20/1987								2:27 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
WASH. DC.		U.S.A.										Prince George's County, MD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Laurel		Greater Laurel/Beltsville Hospital		RET.-ACCOUNTANT		FED. GOV'T.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.		P.G.C.		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2207 BEECHWOOD RD.												20783	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
THOMAS		AGNES		NO		579-22-8225		E. VANCE LENNON		274 JANET DR.										LOTHIAN, Md. 20711	
		LENNON																			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

22b. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE Dennis F. Smyth TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12/21/87

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		12-26-1987		CHAMBERS CREMATORY		RIVERDALE, P.G.C., Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO.		RIVERDALE, Md. 20737		DEC 30 1987			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

NOV 15 1955

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

TO: SAC, NEW YORK (100-100000)

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

RECEIVED NOV 15 1955



100-100000

NOV 15 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 35600
REG. NO.FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Catherine Howard			2a. DATE OF DEATH MONTH DAY YEAR 12-1-87			2b. HOUR 11:45 PM		
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 28 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wm. D.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.	13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11515 Laurel Walk Dr				
14. FATHER'S NAME FIRST MIDDLE LAST David West		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah West						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-36-8264		17. INFORMANT ADDRESS Faye Brown 11515 Laurel Walk Dr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Heart Dis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular accident, Dementia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 6/85 to 12-1-87, that (I) (we) last saw the deceased alive on 12-1-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Mamunah		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-1-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.G. Mamunah, MD		22e. ADDRESS 14201 Laurel Park Dr Laurel, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/87		23c. NAME OF CEMETERY OR CREMATORY Wilson Mem Ch Gr		23d. LOCATION CITY OR TOWN COUNTY STATE Gambrells H.A. MD		
24. FUNERAL DIRECTOR NAME William Reese & Sons		ADDRESS Annapolis, MD		25a. DATE REC'D. BY REGISTRAR DEC 02 1987		25b. REGISTRAR'S SIGNATURE John Davidson		

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076149 DEC 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35601

1- STATE MARYLAND		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-19-87		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6-28-45	
6. AGE (IN YEARS) 42 YRS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-19-87		7d. HOUR M	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		10. CITY OR TOWN OF DEATH Clinton	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6604 Clinton Manor Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Justice Dept.		12b. KIND OF BUSINESS OR INDUSTRY Law-Gov't.	
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Clinton	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Schultz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Hubacher		16. SOCIAL SECURITY NO. 217-44-6712-0	
17. INFORMANT Rose Schultz		18. ADDRESS Same as 13a-e		19. DATE OF OPERATION N/A	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>suicide disorder</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		21. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A		22. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md		24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735		25. DATE REC'D. BY REGISTRAR DEC 24 1987	

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION
N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
N/A

20. AUTOPSY?
YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
N/A

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
N/A

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *Augusta R. Rodriguez* TITLE (SPECIFY) _____ M.D. _____ MEDICAL EXAMINER DATE SIGNED 12-19-87

EXAMINER'S NAME (TYPE OR PRINT) *Augusta R. Rodriguez MD* ADDRESS *3009 Royburn Ct. Cap Spring, Md 20748*

07/84
25MDHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 3 0 2

1. DECEASED NAME (TYPE OR PRINT) Nancy Jo Husk			2a. DATE OF DEATH December 26, 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH July DAY 20 YEAR 1936		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH College Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9749 52nd Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland P.G. County College Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Marcus L. Luther			15. MOTHER'S MAIDEN NAME Gladys N. Miner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-34-5365		17. INFORMANT Ford E. Husk (Husband) College Park, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). glioma of BRAIN AND Spinal cord DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 1979	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Spinal Cord tumor	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 1979 to Dec 26 , 19 87 , that (he) (we) lost saw the deceased alive on Dec 6 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert Gerwin		DEGREE MD	22c. DATE SIGNED 12/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Gerwin MD		22e. ADDRESS 7500 Hanover Pkwy Greenbelt Md 20770	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/29/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. PREPARATION BY (NAME) (ADDRESS) Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR DEC 31 1987	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D NO. 30603

FOR
STATE
REGISTRAR

1- DECEASED NAME (Type or Print) Lucille Zelma IJEOMAH		2a. DATE KNOWN OF DEATH MONTH 12 DAY 31 YEAR 1987		2b. HOUR 8	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 1943	6. AGE (LAST BIRTHDAY) 44 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Seat Pleasant	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 905 Cedar Heights Drive		13f. CITY OR TOWN 20743	
14. FATHER'S NAME FIRST Harold MIDDLE Turne LAST Turne		15. MOTHER'S MAIDEN NAME FIRST Ada MIDDLE Matthews LAST Matthews		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 577-64-1630		17. INFORMANT Edward Ijeomah		ADDRESS Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease (b) disease (c) disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5JAN 1988		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery	
23d. LOCATION CITY OR TOWN Suitland		COUNTY PG		STATE MD	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Funeral Home Suitland Md		25a. DATE REC'D. BY REGISTRAR JAN 5 1988	
25b. REGISTRAR'S SIGNATURE Julia Swiden					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD, "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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10-11-12

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16-17-18



19-20-21

22-23-24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36604
REG. NO.1 - FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) ANNETTE D JACKSON			2a. DATE OF DEATH MONTH DAY YEAR 12 6 87		2b. HOUR 7:30 A.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR NOV. 24, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teachers' Aid		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE MD.		13b. COUNTY P.G.	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Dixon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Crittenton		13e. STREET ADDRESS / ZIP CODE 4543 Dallas Place 20748	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Kevin Jackson 3922 Weller Rd. Wheaton MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Respiratory arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Malignant Pleural effusion

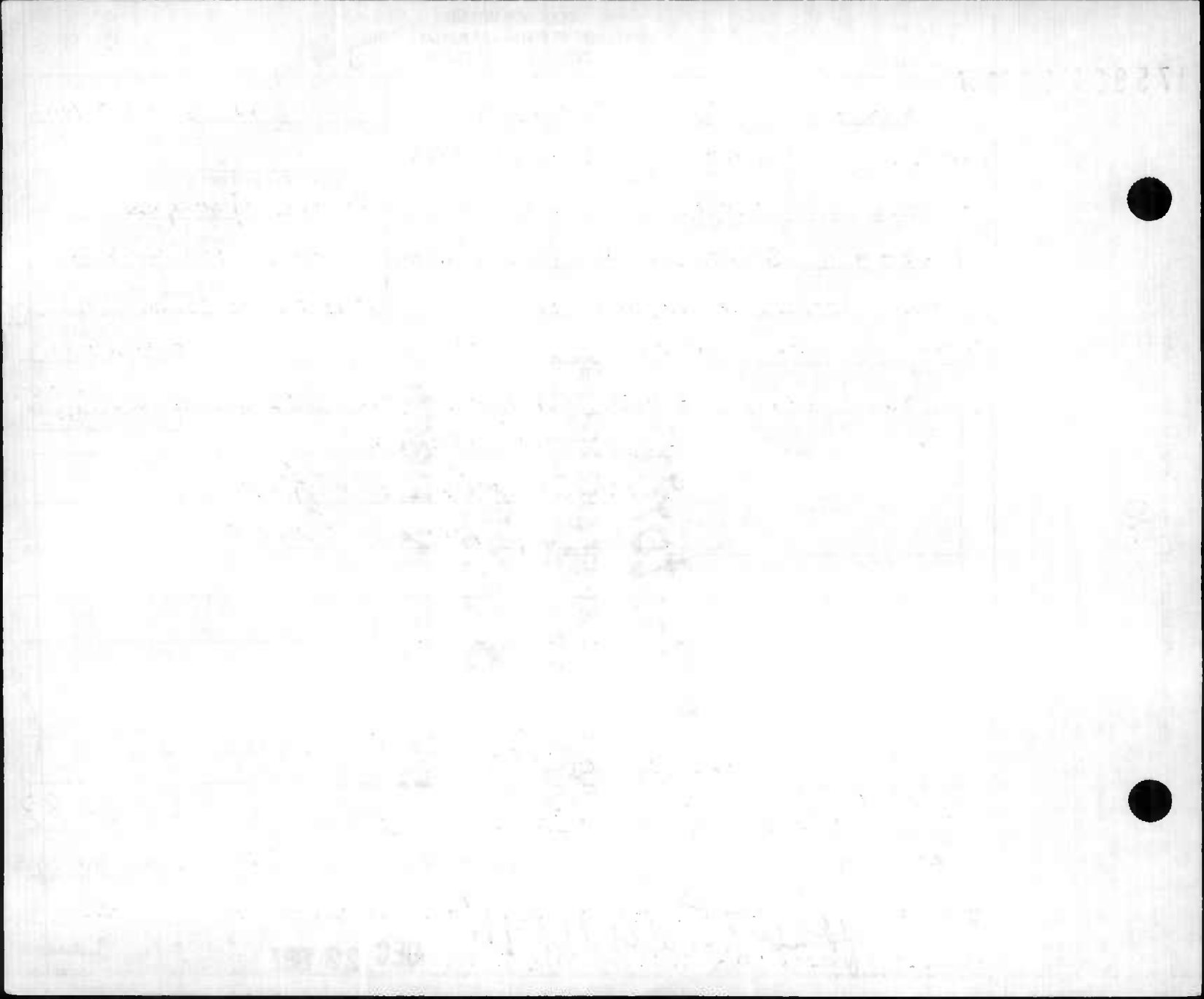
DUE TO, OR AS A CONSEQUENCE OF

(c) Terminal Breast CancerPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MD.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5/87</u> to <u>12/6/87</u> that (I) (we) lost saw the deceased alive on <u>12/5/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Kevin Jackson MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12.06.87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN JACKSON		22e. ADDRESS 1300 MERCANTILE LANE #130 LANDOVER MD 20785	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD.
24. FUNERAL DIRECTOR NAME Stewart Funeral Home 4001 Benning Road,		25a. DATE REC'D. BY REGISTRAR DEC 22 1987	25b. REGISTRAR'S SIGNATURE John L. Stewart



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36605
REG. NO.FOR
1- STATE
REGISTRAR

075892 DEC 23 1987		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR		2b HOUR M	
		CLARENCE A. JACKSON					12-16-87		8.50P	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boston, Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES				MD
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE AND STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Trucker		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE MD.		13b COUNTY P.G.		13c CITY OR TOWN Glenarden		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3034 Brightseat Rd. 20801		
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		Unknown		Unknown				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS 405 Division Ave. N.E. Donald Whoie Washington, D.C.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myeloid leukemia</u> (c) <u>(Erythroleukemia)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>10/30</u> , 19 <u>87</u> , to <u>12/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Krita K. Shan</u>		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/17/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT) KRITA K. SHAN		22e ADDRESS 14333 Lanet Bowie Rd Lanet MD 20708								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec 24, 1987		23c NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Landover, MD.				
24 FUNERAL DIRECTOR NAME Stewart Funeral Home		24b ADDRESS 4001 Benning Road, N.E. Washington, D.C.		25a DATE REC'D. BY REGISTRAR DEC 22 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Landover				



DHMH - 17
(VR A15 ME (5))

0776-12 JAN 11 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36607
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Nellie</i>		MIDDLE <i>T.</i>		LAST <i>JENNINGS</i>		20. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>12-30 1987</i>		21. HOUR M <i>87</i>	
3. SEX <i>Female</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>FEB 7, 1896</i>		6. A. (IN YEARS) LAST BIRTHDAY <i>91</i> YRS.		IF UNDER 1 YR. MONTHS DAYS <i>12-30 1987</i>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>12-30 1987</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>99999</i>	
10. CITY OR TOWN OF DEATH <i>LANHAM</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DOCTORS HOSPITAL</i>		12c. STREET ADDRESS <i>55 COCKRELL AVENUE</i>		12d. CITY OR TOWN <i>ALEXANDRIA</i>		12e. STATE <i>VIRGINIA</i>		12f. COUNTY <i>PRINCE GEORGES</i>	
13a. FATHER'S NAME FIRST <i>FRANKLIN</i>		MIDDLE <i>BENJAMIN</i>		LAST <i>GREENWALT</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i>		MIDDLE <i>AGNES</i>		LAST <i>LESSEY</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-38-7224</i>		17. INFORMANT <i>SON</i>		ADDRESS <i>7504 CREIGHTON</i>		THOMAS F. JENNINGS/DR. COLLEGE PARK, MD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20740</i>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>888</i> IMMEDIATE CAUSE <i>Right hip fracture with complications</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>20740</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>20740</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION <i>12-17-87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Right hip fracture</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>1500 P.M. 12-17-87 Found on sitting on the floor by her bed</i>		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>1500 P.M. 12-17-87</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Found on sitting on the floor by her bed</i>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Marvyn Home</i>		21e. LOCATION STREET <i>5805 Green Chapel Rd, Hyatts. Pr. Geo</i>		21f. COUNTY <i>Pr. Geo</i>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		M.D. <i>5009 Rayburn Ct, Temple Hills, MD</i>		MEDICAL EXAMINER <i>5009 Rayburn Ct, Temple Hills, MD</i>		DATE SIGNED <i>12-30-87</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	
23b. DATE <i>JAN 4, 1988</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATL CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>ARLINGTON</i>		COUNTY <i>VIRGINIA</i>		STATE <i>VIRGINIA</i>		24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>	
25a. DATE REC'D. BY REGISTRAR <i>JAN 7 1988</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		25c. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		25d. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		25e. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		25f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH-17
(VR A15 ME (5))

077-1108

MAILED JAN 21 1908

207 COTTON NO. 2

MAILED JAN 21 1908

MAILED JAN 21 1908

MAILED JAN 21 1908

MAILED JAN 21 1908

MAILED JAN 21 1908

BP_____

DHMH - 17

(VR A15 ME (5))

①

075304 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove can property pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4) 6633

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36609

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PELMAR E. JETT			2a. DATE OF DEATH MONTH DAY YEAR 12 04 87			2b. HOUR 4:45P	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1933		6. AGE (IN YEARS (LAST BIRTHDAY)) 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brown Sta. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Samuel Jett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Cecelia McKenzie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OF SERVICE) Yes 1956-1961			
16b. SOCIAL SECURITY NO. 220-28-7431		17. INFORMANT ADDRESS Leslie M. Jett Same as 13 A-E					
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases to DUE TO, OR AS A CONSEQUENCE OF (c) brain & liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:18 86 12 4		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 87			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9401 INDIAN HEAD HWY. FT. WASHINGTON MD		22c. DATE SIGNED	
22a. I certify that (I) (this hospital) attended the deceased from 9:18 86 to 12:4 87 that (I) (we) last saw the deceased alive on 12:4 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David N. Robb, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID N. Robb, M.D.							
22e. ADDRESS 9401 INDIAN HEAD HWY. FT. WASHINGTON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince George's MD	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE RECD. BY REGISTRAR DEC 16 1987			
25b. REGISTRAR'S SIGNATURE Old Alexander Ferry Rd Clinton, Md. 20735							

077241 JAN 3 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. HOUR
		Emily Burton Johnson					MONTH DAY YEAR 12-30 1987		AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Feb. 23, 1920	67 YRS.	MONTHS DAYS	HOURS MIN.	MONTH DAY YEAR 12-30 1987		AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.		NEVER MARRIED WIDOWED DIVORCED		Prince George's County MD.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham		Doctor's Hospital of P.G. County				Assistant Housekeeper Hospital		Sibley	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		P.G.		Berwyn Heights		YES X NO		5618 Ruatan Street 20740	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST William Burton Markward				FIRST MIDDLE LAST Ruth Violet Dempsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17b. ADDRESS			
No		579-28-1759		(Husband)		5618 Ruatan Street			
				Bernard J. Johnson		Berwyn Heights, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE TIME BETWEEN ONSET AND DEATH 20740
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
								YES NO X	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident Suicide Homicide Undetermined manner									
Autopsy Inspection Inquiry and in my opinion									
Actual Signature: <u>Augusto P. Rodriguez</u> M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-31-87									
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		12/31/87		Metropolitan Crematory		Alexandria P.G. Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Funeral Home, P.A.				JAN 5 1988		<u>John Burton</u>			
4739 Baltimore Avenue Hyattsville, Md. 20781									

07/84
25M

BP
DHMH - 17
(VR AT 5 ME (5))

07-10-1930

12-30-30
12-30-30



James H. Hargis

James H. Hargis

12-30-30

JAN 5 1931

074699 DEC 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36611
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JIMMINEY DERRICK JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 12 07 87		2b. HOUR 9 35A M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 02 02 63		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES' MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Producer		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE MARYLAND	13b. COUNTY P.G.	13c. CITY OR TOWN CAPITOL HTS.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1006 BROOK RD., 20743	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUNICE SHAMBERGER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-50-9671		17. INFORMANT ADDRESS EUNICE BOONE (MOTHER) SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumocystis Carinii AIDS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AIDS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>12/7</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>12-1-87</u> 19 <u>12/7</u> to <u>87</u> 19 <u>87</u> , that (I) (we) lost					
22b. SIGNATURE <u>E. Tellawi</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Essam Tellawi</u>		22e. ADDRESS PRINCE GEORGE HOSPITAL CENTER CHEVERLY MD 341-3300			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-12-87	23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MD.	
24. FUNERAL DIRECTOR VANN & WILLIAMS, 4804 Ga. AVE., N.W., WASH., D.C.		25. DATE REC'D. BY REGISTRAR DEC 10 1987		25. REGISTRAR'S SIGNATURE <u>Gina Burton</u>	

BP

101130 000470

20X COLLECTED 10/2/70

075315

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. REAL-
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS
 AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND - 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

35612

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (FIRST MIDDLE LAST) Wonderful Johnson		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 11 29 87		2b. HOUR 9:51A
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 01 07 63	6. AGE (IN YEARS) (LAST BIRTHDAY) 25 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 25
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		10. CITY OR TOWN OF DEATH Cheverly		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY NAVY
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE MD	13b. COUNTY PG	13c. CITY OR TOWN SEAT PLEASANT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6203 ADDISON ROAD
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE GASKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-94-7350		17. INFORMANT BEATRICE JOHNSON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions: if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 9:13 A.M. 11 29 87		21b. TIME OF INJURY HOUR MONTH DAY YEAR 9:13 A.M. 11 29 87		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK road		21f. LOCATION STREET CITY OR TOWN COUNTY Central Ave nr. Addison Rd, Seat Pleasant, P.G. Co, MD.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Mario F. Golle, Jr.		TITLE (SPECIFY) ASSISTANT MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.		ADDRESS 111 Penn St.		DATE SIGNED 11/30/87
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/4/87	23c. NAME OF CEMETERY OR CREMATORY harmony memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG MD		23e. DATE REC'D. BY REGISTRAR DEC 14 1987		
24. FUNERAL DIRECTOR NAME ADDRESS Comer-Hodges 4901 Marlboro Pk. Coral Hills, Md		25. REGISTRAR'S SIGNATURE Julia Tindon-Badger		

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

003301 1703

TO THE DIRECTOR OF THE

IN THE UNITED STATES

WASHINGTON, D.C.

2000 ADDISON ROAD

NEW YORK, N.Y.

NY

ATTN:

STATION

NEW YORK

NY

NY 10011-1000

211-10-100

NY

NY

THROUGH

RECEIVED

12/1/51

NY

072906

NOV 24 87

Item 196 per phone - Hosp
FOR
1- STATE
- REGISTRAR
12/17/87 DHDSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 35513
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DORIA JONES		2a. DATE OF DEATH MONTH DAY YEAR 11-17-87		2b. HOUR 1 20PM M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 17 48		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Govt			
13a. STATE MD.		13b. COUNTY PG.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Hubert E. Kent, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lannie Boykin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Dwight R. Jones/2211 Columbia Ave.		ADDRESS Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLI DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 11/13/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INCARCERATED HERNIA & Ruptured Appendix		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/13/87 to 11/17/87, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Elwood Holland, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elwood Holland, MD		22e. ADDRESS 6492 Landover Rd. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/22/87		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery/Wilson	
23d. LOCATION CITY OR TOWN COUNTY STATE Wilson N.C.		24. FUNERAL DIRECTOR NAME ADDRESS J.B. Jenkins Funeral/7474 Landover Rd. Landover, Md.			
25a. DATE REC'D BY REGISTRAR NOV 23 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

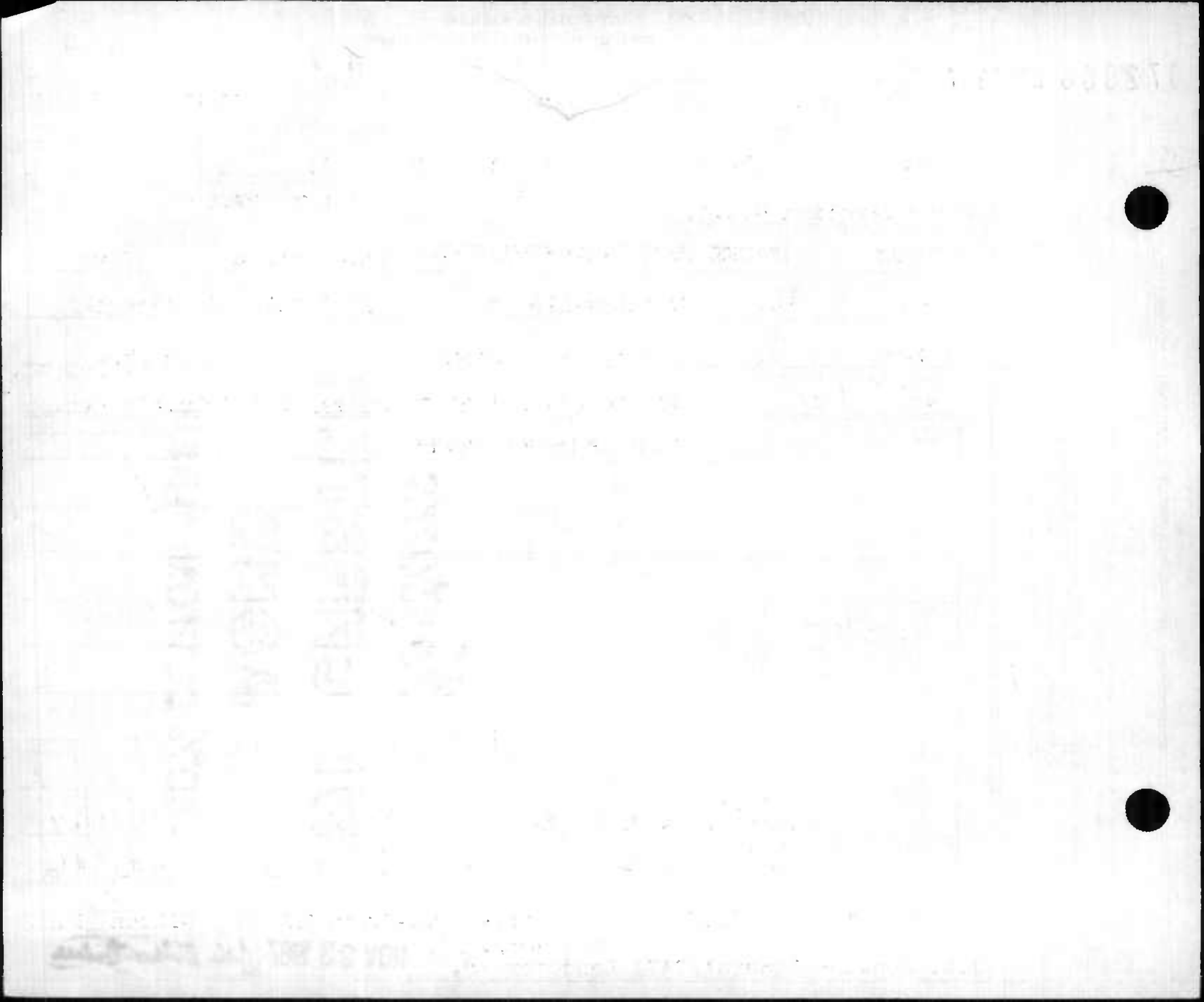
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and consulted.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOYCE JONES					2a. DATE OF DEATH MONTH DAY YEAR DEC 20, 1987		2b. HOUR 7:18 ^P		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 26, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY TEMPLE HILLS		13c. CITY OR TOWN TEMPLE HILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4535 DALLAS PLACE / 20748	
14. FATHER'S NAME FIRST MIDDLE LAST MARION TRICE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SISSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT RAYMOND JONES		ADDRESS 4535 DALLAS PLACE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSEMINATED CARCINOMA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/16 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 12/20 87					
22a. I certify that (1) the hospital attended the deceased from 12/16 87 to 12/20 87 that x (we) lost saw the deceased alive at above; (2) the hospital (did not) view the body after death; 19 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank M. Ryan M.D.				22e. ADDRESS 9401 Inman Henrichs Ft. Wash Md 20744					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY QUANTICO NAT'L.		23d. LOCATION CITY OR TOWN COUNTY STATE TRIANGLE VA.			
24. FUNERAL DIRECTOR [Signature]		CUNNINGHAM FUN. HM		ALEXANDRIA, VA.		25. DATE REC'D BY DEPT. OF HEALTH DEC 24 1987			

[Faint, illegible handwritten notes]

076883 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 30015			
1. DECEASED NAME (TYPE OR PRINT) Mary Jones				2a. DATE OF DEATH MONTH DAY YEAR 12 20 87 2b. HOUR 8:45am			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 / 8 / 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pineview Manor Ext Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILIES	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE M.D. 13b COUNTY P.G. 13c CITY OR TOWN MARLBORO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8505 WESTPHALIA RD. 20772			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM CURTIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE SEWELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-9948		17. INFORMANT ADDRESS 8505 WESTPHALIA RD. DOROTHY LLOYD UPPER MARLBORO M.D.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Multiple myocardial Infarcts DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Cardiac Cachexia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/19/87 12/19/87, 19, to 12/20/87 19, that (I) (we) last saw the deceased alive on 12/19/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Ellie Sayan MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ELLIE SAYAN MD.				22e. ADDRESS 5804 Landover Rd. CHEVERLY, MD. 20784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-28-87		23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MARYLAND	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		ADDRESS 4339 HUNT PLACE, N.E.		25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR SIGNATURE Julia Gordon-Rodman	
WASHINGTON, D.C. 20019							

BP

018083-01410

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

Handwritten notes and signatures are visible across the page, including the word "ACTION" written vertically in the center. The text is mostly illegible due to fading and bleed-through.

077277 JAN 10

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 30616
REG. NO.

DECEASED NAME (Last, first, middle) NELLIE BEA JONES				7a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22 1987		7b. HOUR 8:15A M	
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR NOV. 21 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEOCO		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY P.G. 13c. CITY OR TOWN UPPER MARLBORO				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 31 THURSTON DR. 20772	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ARTHUR CARTWRIGHT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORDERIA BLUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-12-7809		17. INFORMANT ADDRESS BONNIE BAUMANN - daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Tumor - CHRONIC and acute Bronchitis 2 months</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema - congestive Heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Peripheral Vascular Insufficiency - Renal failure -</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December 19, 1987</u> , to <u>December 22, 1987</u> , that (I) (we) last saw the deceased alive on <u>December 22, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE		22c. DATE SIGNED 12-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAXIMO SINGER				22e. ADDRESS 6001 Landover Road Cheverly, Md 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-23-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 05 1988	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

011555 200-3-10

074197 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36017
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GAIL Thurman Judd, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 12 1 87		2b. HOUR 0750 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 29, 1913	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Map Specialist	12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3918 Longfellow Street 20781	
14. FATHER'S NAME FIRST MIDDLE LAST Gail Thurman Judd, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian M. Frazier		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II	17. INFORMANT Doris M. Judd (Wife) Hyattsville, Md. 20781	ADDRESS 3918 Longfellow Street		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) LUNG CANCER

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

RESPIRATORY FAILURE, LUNG ABSCESS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 24, 1987, to Dec 1, 1987, that (I) (we) last saw the deceased alive on Nov 30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.			
22b. SIGNATURE Ralph Boccia, MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Boccia, MD		22e. ADDRESS 14801 Physicians Lane #271 Rockville MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/03/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR DEC - 4 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and returned to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

105-33701-100

Page 10 of 10

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial system and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in entering data into the system, from initial verification to final posting.

3. The third part of the document addresses the issue of data security. It discusses the various measures that should be implemented to protect sensitive information from unauthorized access or loss.

4. The fourth part of the document discusses the importance of regular backups. It explains how these can help to prevent data loss in the event of a system failure or disaster.

5. The fifth part of the document discusses the importance of training. It explains how ensuring that all staff are properly trained can help to reduce the risk of errors and improve the overall efficiency of the system.

21
1

6. The sixth part of the document discusses the importance of documentation. It explains how maintaining detailed records of all system changes and updates can help to ensure that the system remains up-to-date and secure.

7. The seventh part of the document discusses the importance of communication. It explains how keeping all stakeholders informed of system status and changes can help to ensure a smooth transition and minimize disruption.

8. The eighth part of the document discusses the importance of monitoring. It explains how regularly checking system performance and logs can help to identify potential issues before they become major problems.

9. The ninth part of the document discusses the importance of testing. It explains how conducting regular tests of the system can help to ensure that it is working as intended and that any issues are caught early.

10. The tenth part of the document discusses the importance of review. It explains how regularly reviewing the system's performance and the effectiveness of the implemented measures can help to ensure continuous improvement.

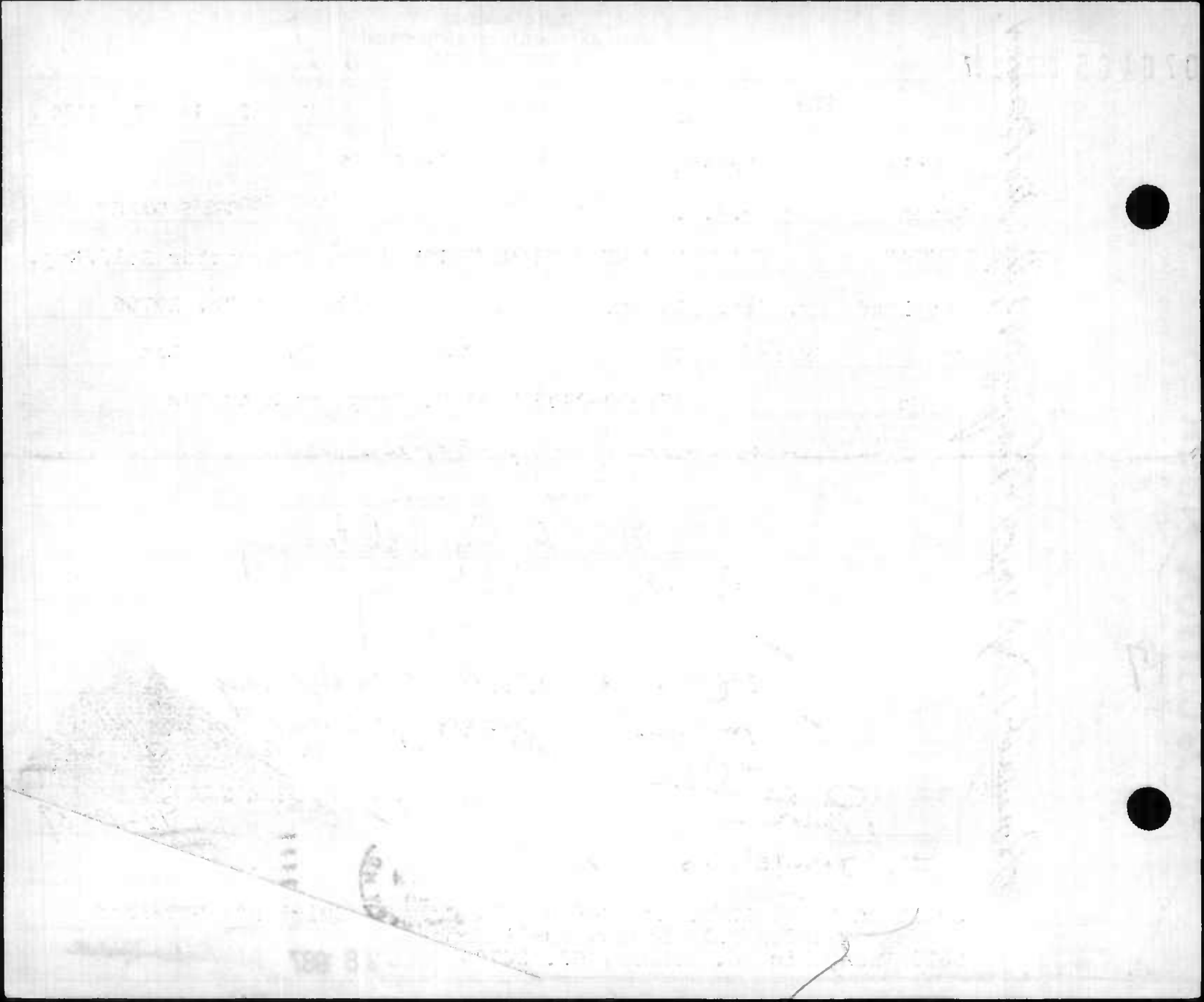
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and 3 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT NOTE: If item 21a is checked, item 18 shows any injury, or other trauma to the body, the medical examiner must be notified at once. *Amended 12/20/87 by Dr. [Signature]*

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 87 36518						
1. DECEASED NAME (TYPE OR PRINT) STAN B. JUNG					2a. DATE OF DEATH MONTH DAY YEAR 12 18 87				2b. HOUR 1130 A		
3. SEX Male		4. RACE Korean		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen, Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self/Emp.			
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9930 Elm St. 20706		
14. FATHER'S NAME FIRST MIDDLE LAST Kyung Hoon Jung			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sook Hee Lee			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-90-3125		
17. INFORMANT ADDRESS Bill H. Jung same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Neg Sepsis</u> 907 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>Struck by lightning</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Struck by lightning</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 P.M. 8-8 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Struck by lightning</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Back yard</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>9930 Elm St. Lanham, Pr. Georges, Md.</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/18/87</u> to <u>12/18/87</u> , that (I) (we) last saw the deceased alive on <u>12/18/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>			DEGREE <u>Physician covering Dr. Yabawara</u>			DATE SIGNED 12-19-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Bertolino			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland				
24. FUNERAL DIRECTOR Rendon/Hale Lanham Fun'l Home						25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
26. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706											



076918 DEC 31

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 DEPT. OF
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3730519

1. DECEASED NAME (TYPE OR PRINT) GEORGE L KAVAKOS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 26, 1987			2b. HOUR 03:14 A		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-27-1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (12b. OF WORK FOR LAST 12 MONTHS) Sales Representative Private		
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Kavakos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Paperres					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-9194		17. INFORMANT ADDRESS Louis B Kavakos 10010 Hackberry La. Columbia MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACIDOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE RENAL FAILURE</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEPSIS</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>87</u> , to <u>12/26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Gregory A. Compton MD</u>						22c. DATE SIGNED 12-26-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A. COMPTON MD						22e. ADDRESS 5317 Cherry Lane Cherry Laurel MD 20707		
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-28-1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		
24. FUNERAL HOME NAME Donald Borgwardt				4400 Powder Mill Rd. Beltsville Md. 20705		25a. DATE REC'D. BY REGISTRAR DEC 31 1987		
25b. REGISTRAR'S SIGNATURE <u>Lia Fenton-Rodden</u>								

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove calligraphers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 36620	
1. DECEASED NAME (TYPE OR PRINT) FIRST David MIDDLE John LAST Keppel DAVID JOHN KEPPEL						2a. DATE OF DEATH MONTH 12 DAY 16 YEAR 87				2b. HOUR 939 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE MD		13b. COUNTY Pr. Geos.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4922 LaSalle Road/20782			
14. FATHER'S NAME FIRST DAVID MIDDLE A. LAST Keppel				15. MOTHER'S MAIDEN NAME FIRST ANN MIDDLE -- LAST BROWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-48-1523		17. INFORMANT Margaret M. Kelley, Chevy Chase, MD 20815				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) General debility DUE TO, OR AS A CONSEQUENCE OF (c) 			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile dementia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 82 to 16 Dec 19 87 , that (I) was last saw the deceased alive on 14 Dec 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) we they (did not) view the body after death.											
22b. SIGNATURE Robert T. Kelley				DEGREE 				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 16 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Kelley				22e. ADDRESS 8218 Wisconsin Ave Bethesda Md 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR DEC 23 1987		25b. REGISTRAR'S SIGNATURE			

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Real Estate

Hickner

4925 Lashlie Road\20782

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Vol. 11. No. 3190

Washington, D.C.

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5130 Woodchuck Ave., N.E., Washington, D.C. 20050

078067 JAN 13 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36621
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Ellen King			2a. DATE OF DEATH MONTH DAY YEAR December 29, 1987		2b. HOUR P. 5:00 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Upper Marlboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2105 Ritchie-Marlboro Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edward -- Lusby			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude --- Denton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT ADDRESS 15739 Millbrook Lane Robert King-Laurel, Maryland 20707	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Endometrial Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Multiple intestinal fistulae					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Nov 19 87 to 12/29 87 , that (I) (we) lost saw the deceased alive on 12/29 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Clark Holmes		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Clark Holmes, M.D.		22e. ADDRESS Upper Marlboro, Maryland 20772			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/4/88	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Clinton (Pr. Geo's) Md.		
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home		Upper Marlboro, Maryland 20772		25a. DATE REC'D. BY REGISTRAR JAN 12 1988	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1, 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3730022

1- FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) Wilma Brown Kirchner			2a. DATE OF DEATH MONTH DAY YEAR 12 11 87		2b. HOUR 1:40 pm
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 1 18 32		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurel-Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MD	13b. COUNTY PG	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11501 New Dr. 20705	
14. FATHER'S NAME FIRST MIDDLE LAST John Hoy Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Blancher Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a	17. INFORMANT ADDRESS 8648 Cheshire Court Robert P. Kirchner Jessup, Md. 20794			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiac Arrest</u>			<u>one hour</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension (180/110)</u>			<u>at least 1 1/2 hr. progressive</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>acute abdomen - bowel obstruction</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan - 12/11/87</u> to <u>12/11/87</u> , that (I) (we) last saw the deceased alive on <u>12/11/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>N. Tawani MD</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>12/11/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>N Tawani MD / ABels</u>		22e. ADDRESS <u>9101 Cherm Lane, Laurel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>12/17/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Wash. Crematory</u>	23d. LOCATION CITY OR TOWN COUNTY <u>Laurel P.G. Maryland</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>7601 Sandy Spring Road</u> <u>Fleck Funeral Home, Inc. Laurel, Md. 20707</u>		25. DATE REC'D. BY REGISTRAR <u>DEC 21 1987</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36523
REG. NO.1 - FOR
STATE
REGISTRAR

2a DECEASED NAME (TYPE OR PRINT) MARGARET L. KRISTIENSEN			2b DATE OF DEATH MONTH DAY YEAR 12/12/87		2c HOUR 9:30 PM						
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 10/02/18		6 AGE (IN YEARS LAST BIRTHDAY) 69		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Columbia S.C.		7d CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a USUAL OCCUPATION (IF NOT WORKING, GIVE MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home			
13a STATE Maryland			13b COUNTY P. G.		13c CITY OR TOWN Clinton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8600 Mike Shapiro Rd. 20735		
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Patrick Shealy			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Wessinger			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A					
16b SOCIAL SECURITY NO. 578184014			17 INFORMANT Donna M. Coggins			18 ADDRESS 6804 Friendship Rd Clinton, Md 20735					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic tumor</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Fibrous adhesions of bowel, partial obstruction, Cachexia.</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (a) this hospital attended the deceased from <u>9.21.1987</u> to <u>12.12.1987</u> , that (we) last saw the deceased alive on <u>12.12.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>M. Singh</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) MRIDULA SINGH, M.D.			22e ADDRESS Southern Maryland Hosp. Center 7503 Surratts Road, Clinton Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12/21/87		23c NAME OF CEMETERY OR CREMATORY Maryland Veterans Com		23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince George's MD				
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			24b ADDRESS 16633 Old Aelxander Ferry Rd Clinton, Md 20735			25a DATE REC'D. BY REGISTRAR DEC 24 1987					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 36624 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth L. Langgle				2a. DATE OF DEATH MONTH DAY YEAR December 6, 1987				2b. HOUR 5:45 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 4, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Ft. Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ft. Washington Rehab Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1819 Clayton Drive 20745			
14. FATHER'S NAME FIRST MIDDLE LAST John Langor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Dudash							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-60-2281		17. INFORMANT ADDRESS Patricia A. Osbourn 1819 Clayton Dr. Oxon Hill, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alzheimers Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE OFF WORK <input type="checkbox"/>		21e. PLACE OF INJURY (APPROX. STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 83 Present							
22a. I certify that (1) this hospital attended the deceased from _____ 19 <u>83</u> to _____ 19 <u>Present</u> , that (1) (was) last saw the deceased alive on _____ 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not see the body after death.											
22b. SIGNATURE <u>Herbert Wisotsky</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert Wisotsky, M.D.				22e. ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland					
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				25a. DATE REC'D. BY REGISTRAR 6160 Oxon Hill Rd. Oxon Hill, Md. DEC 09 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36625

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) MARIAM ESTHER LEISHEAR			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1987			2b. HOUR A 10:15 M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 14, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4922 La Salle Road 20782	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Suthard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Berryman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 578-14-8417			17. INFORMANT Nephew Milton H. Hagemann			ADDRESS 3819 Hillcrest Lane Annandale, Virginia 22003			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>48</u> to <u>12/10/87</u> , that (I) (we) lost saw the deceased alive on <u>12/1</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Smith H. O. M.D.</u>			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH H. O. M.D.			22e. ADDRESS 7610 Carroll Ave Takoma Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Maryland		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE REC'D. BY REGISTRAR DEC 14 1987			25b. REGISTRAR'S SIGNATURE <u>J. S. Sullivan-Rodell</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be submitted for review.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE Elizabeth LESLIE					2a. DATE OF DEATH MONTH DAY YEAR 12 14 87 2b. HOUR 9 35A _M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 23 09		6. AGE (IN YEARS, LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES' MD.			
10. CITY OR TOWN OF DEATH CHEVERRY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator Telephone Co		12b. KIND OF BUSINESS OR INDUSTRY C&P	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Maurice C. Downs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah E. Miles		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 579-34-7618		17. INFORMANT (Son) Donald R. Leslie Riverdale, Md. 20737							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uro sepsis DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) G.I. Bleeding (upper)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-06-87, to 12-14-87, that (I) (we) lost saw the deceased alive on 12-11-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Villanor S. Reyes		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Villanor S. REYES, M.D.		22e. ADDRESS 6501 Landover Rd. Cheverly MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/87		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Montgomery Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781									
25. DATE REC'D. BY REGISTRAR DEC 17 1987 REGISTRAR'S SIGNATURE Julia Burton Prince									

DEC 17 1961

076464 DEC 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 35627
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARL LEVINE		2a. DATE OF DEATH MONTH DAY YEAR 12 17 87		2b. HOUR 6 40P ^M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 08 18 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Sadowitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Shotland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 067-12-1834		17. INFORMANT ADDRESS Lawrence Levine same as 13e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diaphragmatic hernia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCD, Diabetes mellitus</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17/87</u> to <u>12/17/87</u> , that (I) (we) last saw the deceased alive on <u>12/17/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>D. Granite, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/18/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. Granite, MD</u>		22e. ADDRESS <u>115 Centerway Greenbelt, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/87	23c. NAME OF CEMETERY OR CREMATORY King David Memo. Gardens Falls Church, Va.	
23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home		25. DATE REC'D BY REGISTRAR DEC 28 1987		
26. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706				

BP

075478 DEC 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Hazel Addie Liggett					12	13	87		6:00 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		October 28, 1902		85		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, DC		U.S.A.				Prince George's County		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial Hospital		Homemaker		own Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		P.G.		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		6112 40th Avenue 20782			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
John Lee Cannon		Minnie Maude Lilley		No		213-48-9029		6114 40th Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE			
22a. I certify that (I) (the hospital) attended the deceased from 11-29-87 to 12-13-87, that (I) (we) lost saw the deceased alive on 12-12-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED					
Angus W. McLaurin, M.D.		3415 Hamilton Street Hyattsville, Md. 20782		12/13/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		12/16/87		Fort Lincoln Cemetery		Brentwood P.G. Maryland					
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons Funeral Home, P.A.		4739 Baltimore Avenue Hyattsville, Md. 20781		DEC 17 1987		John Barker					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3442

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR	
ANTHONY		J.		Lindsey		LINDSAY		<input checked="" type="checkbox"/> ESTI- MATED		12		12		19		87	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR	
Female	Black	12 20 65		21		MONTHS		DAYS		Pronounced DEAD		12		12		19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		24. HOUR		M		P	
Wash. D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County		Assistant Plummer				8:55		M		P	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Cheverly		Prince George's Gen. Hosp.		Assistant Plummer				MD.		P.G.		Lanham		YES <input type="checkbox"/> NO <input type="checkbox"/>		3200 Reed St. #2122	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS		17. ADDRESS		17. ADDRESS		17. ADDRESS	
George		David Lindsey, Sr.		Mildred L. McQueen		No		578-98-6604		Mildred Lindsey-mother		Lanham MD		20706		3200 Reed St	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Gunshot wounds of chest</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>8:20</u> MONTH <u>12</u> DAY <u>12</u> YEAR <u>87</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>bldg.</u>		21f. LOCATION CITY OR TOWN <u>5 Cindy Lane, Capitol Heights, Prince George's</u>	

22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Ann M. Dixon, M.D.		12-13-87	
ADDRESS		111 Penn St., Balto., MD 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Dec 18, 1987		Harmony Mem. Park		Landover, MD.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE			
Stewart Funeral Home		Dec 22 1987									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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25M

BP
DHMH - 17
(VR A15 ME (1))

REBIP-PMOTOD 2:00

DAVID B. WILKINSON



075980 DEC 23 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3-5630

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Kimberly</i>		MIDDLE <i>L.</i>		LAST <i>Lilly</i>		2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 2 - 87</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS <i>3 17</i>		IF UNDER 1 YR. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>12-19 87</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>		MD			
10. CITY OR TOWN OF DEATH <i>Camp Springs</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Andrews APB Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Ft. Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7707 Ravine Drive</i>		20744	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bartley K. Lilly</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca L. Hatton</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT ADDRESS <i>Rebecca L. Lilly 7707 Ravine Dr. Ft. Washington, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Isrormy 13 with congenital heart.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>12-19-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez MD</i>				ADDRESS <i>5709 Foxglove Ct. Cp Sp. Md 20748</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/21/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Clinton P.G. Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>George p. Kalas Funeral Home</i>				ADDRESS <i>6160 Oxon Hill Rd. Oxon Hill, Md.</i>				25. DATE REC'D. BY REGISTRAR <i>DEC 22 1987</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

DEC 2 1950

RECEIVED
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DEC 2 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36631

1. DECEASED NAME (TYPE OR PRINT) LANIE M. LONG			2a. DATE OF DEATH MONTH DAY YEAR 12-17-87		2b. HOUR 11:50 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse - Ret.	12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8404 Dangerfield Pl. 20735
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Long		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Hedrick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-48-3408	17. INFORMANT ADDRESS Vincent H. Gesuero Rte. 2, Box 2350 LaPlata, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) Gram Positive bacteremia.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute myocardial infarction; chronic lymphocytic leukemia with anemia.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-16-1987 to 12-17-1987, that (I) (not lost) saw the deceased alive on 12-17-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Basir Muhammad		DEGREE MD		22c. DATE SIGNED 12-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASIR MUHAMMAD F. KULIA MD		22e. ADDRESS 4135 Piscataway Road, Suite 210 Clinton, MD 20735.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/22/87	23c. NAME OF CEMETERY OR CREMATORY Briery Branch Breth. Cem. Bridgewater		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME George p. Kalas Funeral home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR DEC 21 1987	25b. REGISTRAR'S SIGNATURE Julia Fisher-Randall

BP

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076774 DEC 31 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5632

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Margie

Sean

Loring

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12-26 1987
2b. HOUR
M

3 SEX
Female

4 RACE
White

5. DATE OF BIRTH
MONTH DAY YEAR
NOV 6 1944

6. AGE (IN YEARS)
(LAST BIRTHDAY)
43 RS.

IF UNDER 1 YR.
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN.

2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-26 1987
2d. HOUR
M

7a. BIRTHPLACE (STATE OR

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

10. CITY OR TOWN OF DEATH

ANDREWS AFB

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

MALCOLM GROW MEDICAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)

CAFETERIA WORKER FOOD

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MARYLAND

13b. COUNTY
PR GEORGE

13c. CITY OR TOWN
SUITLAND

13d. INSIDE CITY LIMITS?
YES ☐ NO ☐

13e. STREET ADDRESS
#103
5200 BELL GREEN ST 20746

14. FATHER'S NAME
FIRST

WALTER

MIDDLE

W

LAST

FOSS

15. MOTHER'S MAIDEN NAME
FIRST

MAGGIE

MIDDLE

B

LAST

GIBSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.
213-44-6561

17. INFORMANT
ADDRESS
HAROLD R LOVING SAME AS #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

Carcinoma of the lung, metastases

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL
SIGNATURE

Augusto P. Rodriguez

M.D.

MEDICAL EXAMINER

DATE
SIGNED

12-26-87

EXAMINER'S NAME
(TYPE OR PRINT)

Augusto P. Rodriguez MD

ADDRESS

5009 Rayburn Ct. Cape Pr. George Md

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

30 DEC 1987

23c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY

23d. LOCATION
CITY OR TOWN

SUITLAND

COUNTY

PG

STATE

MD

24. FUNERAL DIRECTOR

NAME ROBERT E WILHELM

FUNERAL HOME

SUITLAND, MD

25a. DATE REC'D. BY REGISTRAR

DEC 29 1987

25b. REGISTRAR'S SIGNATURE

R. E. Wilhelm

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY. PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 9, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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Washington DC

Manor Care Nursing Facility

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

87 REG. NO. 36633

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vivian J. Lucas			2a. DATE OF DEATH MONTH DAY YEAR 12 6 87		2b. HOUR 4:10A
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 13 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Fort Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2407 Grange Hall Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt
13a. STATE Maryland		13b. COUNTY P. Georges	13c. CITY OR TOWN Ft. Wash.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry M Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice P Dowdy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 224220462		17. INFORMANT Mervin A. Lucas		17. ADDRESS 2407 Grange Hall Court Ft Washington, Md. 20744	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>inaction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>Feb 20 1987</u> to <u>Dec 6 1987</u> , that (1) (we) last saw the deceased alive on <u>19 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		22c. DEGREE <u>MD</u>		22d. DATE SIGNED <u>12/7/89</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D.J. HAIDAK MD</u>		22f. ADDRESS <u>Antonia Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-10-87		23c. NAME OF CEMETERY OR CREMATORY Jackson Family Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Meherrin Luenburg Va.		24. FUNERAL DIRECTOR NAME J.B. Jenkins		25a. DATE REC'D. BY REGISTRAR DEC - 9 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP _____

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1- FOR STATE REGISTRAR per med exam 2c, 6-14-81
G640 ME

4-88 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0000

074193 DEC

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	AFTERNAME	DATE OF DEATH MONTH DAY YEAR		TIME OF DEATH HOUR MIN.		PLACE OF DEATH CITY/TOWN STATE	
Louis George Lushine					11	27	1987			
SEX	RACE	DATE OF BIRTH MONTH DAY YEAR	AGE IN YEARS (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	DATE OF DEATH MONTH DAY YEAR		TIME OF DEATH HOUR MIN.		PLACE OF DEATH CITY/TOWN STATE
Male	White	Sept. 24, 1916	71			11	27	1987	5AM	Baltimore City or County of Death
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH				
Minnesota		U.S.A.				Prince George's County				
CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		KIND OF BUSINESS OR INDUSTRY		
Adelphi		Presidential Woods Nursing Home				Accountant		G.A.O.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		STATE		CITY OR TOWN	INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		STREET ADDRESS			
Maryland		P.G.		Greenbelt	X		115 Periwinkle Court		20770	
FATHER'S NAME FIRST MIDDLE LAST		MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		INFORMANT		ADDRESS				
Michael Lushine		Marie (Unavailable)		Lucille Lushine (Wife)		15 Periwinkle Ct.				
WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		SOCIAL SECURITY NO.		INFORMANT		ADDRESS				
No		469-12-0100		Lucille Lushine (Wife)		Greenbelt, Md.				
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>Arteriosclerotic Cardiovascular Disease</u> IMMEDIATE CAUSE (a) <u>Neck injuries with complications</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROPRIATE AGENCY BETWEEN ONSET AND DEATH 20770
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Quadriplegia due to neck injuries</u>										
DATE OF OPERATION		CONDITION FOR WHICH OPERATION WAS PERFORMED?				AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 15 1987		HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) one car accident						
INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) road		LOCATION STREET CITY OR TOWN COUNTY STATE Minneapolis Minnesota						
I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED				
Mario F. Golle, Jr., M.D.		Assistant				11/27/87				
BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE		NAME OF CEETERY OR CREMATORY		LOCATION CITY OR TOWN COUNTY STATE				
Cremation		12/01/87		Metropolitan Crematory		Alexandria Virginia				
FUNERAL DIRECTOR				DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Funeral Hom., P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				DEC - 4 1987		Julia Denton-Penderson				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN THE CERTIFICATE TO THE HEALTH DEPARTMENT OF BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL OF THE BODY.
PENDING

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENNSION STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Marian V. Lynch								Dec. 19, 1987		8:45PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		July 26, 1899		88		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.J.		U.S.A.				Prince George				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		Carroll Manor				Land Lord		Rooming House			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Prince George		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4922 LaSalle Road		20782	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John Lynch				Mary Kane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		578-03-0215		Thomas J. Whitehead		4931 Mass. Ave., NW		Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: Cerebral Vascular Accident										1 Week	
IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										10 years	
(b) Cerebral Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
Previous Cerebral Vascular Accident											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 20, 1983, to Dec. 19, 1987, that (I) (we) last saw the deceased alive on Dec. 12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
J. Neil Kennedy, M.D.										Dec. 19, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
J. Neil Kennedy						1145 - 19th St., N.W., Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		Dec. 22/87		Mt. Olivet Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DeVol Funeral Home						JAN 4 1988					
Washington, D.C.											

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36630

077461 JAN - 7 1988

1. DECEASED NAME (FIRST, MIDDLE, LAST) James William Macri		2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 29 1987		2b. HOUR 7:30
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 06 87	6. AGE (IN YEARS) LAST BIRTHDAY YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2407 Panther Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Bowie
14. FATHER'S NAME FIRST MIDDLE LAST Domenic Macri		15. MOTHER'S MAIDEN NAME MIDDLE LAST Beatrice Not Available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 098-05-4853		17. INFORMANT ADDRESS William C. Macri, Same as # 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		DATE SIGNED Dec 29 1987
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, MD		ADDRESS 1919 Seminary Road, Silver Spring, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Jan. 2, 1988	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Fairfax, Virginia	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Rd. Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR JAN 6 1988
		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

05-00000000

88611 MOTION PICTURE

WILLIAMSON



076900 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 5 5 3 7

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST Kevin		MIDDLE David		LAST Marsh		7a. DATE KNOWN OF DEATH ESTIMATED 12-25-87		7b. HOUR M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 6 1969		6 AGE (IN YEARS) LAST BIRTHDAY 18 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 12-25-87		7d. HOUR M	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's						MD	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY High School							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3412A Hampton Hollow Dr.					
14. FATHER'S NAME FIRST MIDDLE LAST David Glen Marsh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marsha Lewis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) n/a		17. INFORMANT Marsha Marsh		ADDRESS same as 13e							
18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart & Lung Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION 12-23-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Hernia repair		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 P.M. 12-23-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Rear passenger in vehicular collision.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, PORT, FARM, ETC.) Sheet		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1403 Blake Old Hundred Rd. Laurel, Prince George's Md									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputado		MEDICAL EXAMINER		DATE SIGNED 12-25-87							
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez MD		ADDRESS 5009 Bayview Ct. Cp 5pm. Md 20748											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/87		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Memo. Pk. Cem.		23d. LOCATION CITY OR TOWN Laurel		P.G.		Md.			
24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc.		ADDRESS 7601 Sandy Spring Road Laurel, Md. 20701		25a. DATE REC'D. BY REGISTRAR DEC 31 1987		25b. REGISTRAR'S SIGNATURE Lisa L. ...							

07/84
25M

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DHMH - 17
(VR A15 ME (5))

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Kam Lewis Martin

1910 to 1911

1911 to 1912

1912 to 1913

1913 to 1914

1914 to 1915

1915 to 1916

1916 to 1917

1917 to 1918

1918 to 1919

1919 to 1920

1920 to 1921

1921 to 1922

1922 to 1923

1923 to 1924

1924 to 1925

1925 to 1926

1926 to 1927

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **36633**

1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Patricia Lee Marsh										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 26 1987		2b. HOUR 1:15 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR April 26, 1934		6. AGE (IN YEARS) BIRTHDAY 53	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 0 0 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 26 1987		7d. HOUR 8 P.M.				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD							
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer-Ret.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1800 Castle Blvd					
14. FATHER'S NAME FIRST MIDDLE LAST Paul O'Brien		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. 285 30 7785					
17. INFORMANT William Marsh (Husband)				18. ADDRESS Same as 13E									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute Myocardial Dis.**
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUETO, OR AS A CONSEQUENCE OF
(b)
DUETO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE **Dr. John S. Rogers** M.D. TITLE (SPECIFY) **Dep.** MEDICAL EXAMINER DATE SIGNED **Dec 26, 1987**
EXAMINER'S NAME (TYPE OR PRINT) **Dr. John S. Rogers** ADDRESS **1919 Seminary Rd. S.S. Md.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/30/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi ADDRESS 11800 New Hamp. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE John S. Rogers	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17
(VR A15 ME (5))

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WIND



WIND

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

075929

FOR
STATE
REGISTER

87 REG. NO. 36639

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM Edward MARTIN			2a. DATE OF DEATH MONTH DAY YEAR 12 12 87		2b. HOUR M 4 05PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 25, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Petty Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Peter G. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta R. Hoffman		16. ADDRESS 4401 41st Street 20722			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I 080-14-8951		17. INFORMANT Janice Lee Martin (Wife) Brentwood, Md. 20722			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **12-1**, 19 **87**, to **12-12**, 19 **87**, that (I) (we) lost saw the deceased alive on **12-12-87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME
Francis Gasch's Sons Funeral Home, P.A.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

4739 Baltimore Avenue

Hyattsville, Md. 20781

DEC 22 1987

John Gordon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DEC 21 1965

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[Several lines of illegible text follow, appearing to be a memorandum or letter.]

[Several lines of illegible text, possibly a signature block or distribution list.]

DEC 20 1965

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, that city, injury, or other traumatic event, the medical examiner must be notified by date.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO. 36640						
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laurence Raymond MATTHEWS					3a. DATE OF DEATH MONTH DAY YEAR December 9, 1987			3b. HOUR 5:00P M			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 29 11			6 AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY DuVall High			
13a. STATE Maryland					13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Matthews					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace M. Pendleton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-26-4325A		17 INFORMANT ADDRESS William G. Miles Same as Line #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/10 1987 to 12/9/1987 that (I) (we) lost saw the deceased alive on 12-9-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Dakheel M.D.								DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel M.D.								22e. ADDRESS 14300 Gallant Fox Ln., Bowie, Md. 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-12-87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.C. Maryland		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781						25. DATE REC'D BY REGISTRAR DEC 17 1987 REGISTRAR'S SIGNATURE					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36641

1. DECEASED NAME (TYPE OR PRINT) MAYER WILLIAM HENRY MAYER, JR.			2a. DATE OF DEATH MONTH DAY YEAR 12 2 87			2b. HOUR 3:06 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 06 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Coca-Cola	
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Mayer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Huron			13e. STREET ADDRESS / ZIP CODE Box 402 Route 6 / 20646			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-10-7548		17. INFORMANT ADDRESS Box 833		17. INFORMANT ADDRESS Wm. Daniel Mayer, La Plata, Md. 20646			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-17-1987 to 12-2-1987 , that (I) (we) last saw the deceased alive on 12-1-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G.S. RATH		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-3-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. RATH		22e. ADDRESS Charles Professional Bldg. Waldorf Md. 20681							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-05-87		23c. NAME OF CEMETERY OR CREMATORY Mount Rest		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles, Md.			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.				25a. DATE REC'D BY REGISTRAR DEC - 8 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CO-517

WILLIAM HENRY HAYES

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1893-1894

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 30642

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		James (nmn) McBrierty				December 8, 1987		6:03P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Male		Caucasian		April 19, 1967		80		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Connecticut		United States				Prince George's County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		AMI Doctors' Hospital of Pr. Geo.		Co. Machinist		United Technology			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Prince Geo.		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12/14 Chesney Lane/20715	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Thomas		Catherine		McNeill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		046-14-8675		Geraldine C. McBrierty, Same as # 13.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>		—	
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>aspiration pneumonia</u>		1 hr.	
DUE TO, OR AS A CONSEQUENCE OF			
(c) <u>coronary atherosclerosis</u>		—	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ① chronic obstructive pulmonary disease ② pneumonia ③ bowel obstruction

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11-14-87		bowel obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK							
22a. I certify that (I) (the hospital) attended the deceased from <u>January</u> 19 <u>86</u> to <u>Dec. 8</u> 19 <u>87</u> , that (I) <u>last</u> saw the deceased alive on <u>Dec. 8</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
David A. Boetcher, M.D.				M.D.		12-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
David Boetcher, M.D.				Suite 118 14300 Gallant Fox Lane, Bowie, Md. 20715			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		Dec. 9, 1987		St. James Cemetery		Manchester, Hartford, CT	
24. FUNERAL DIRECTOR NAME		16000 Annapolis Road		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Beall Funeral Home		Bowie, Maryland		DEC 17 1987		Julia B. Boetcher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36644

FOR
1. STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby B McCambridge			2a. DATE OF DEATH MONTH DAY YEAR December 2, 1987		2b. HOUR 7:20 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR March 9, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Railroad		12b. KIND OF BUSINESS OR INDUSTRY Maintenance	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY P.G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9408 Paul Drive 20735
14. FATHER'S NAME FIRST MIDDLE LAST Clifton Truslaw			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Belle Coffey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-07-1124		17. INFORMANT ADDRESS Herbert Thomas Same as 13 A-E		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a). **ACUTE CARDIOPULMONARY ARREST**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**MINUTES.**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **SEVERE ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **EMBOLIC STROKES.****DAYS.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

HYPERTENSIVE CARDIOVASCULAR DISEASE. CEREBRAL ARTERIOSCLEROSIS, ARTHRITIS.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 5 , 19 87 , to Dec. 2 , 19 1987 that (I) (we) last saw the deceased alive on Dec. 2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 		DEGREE M.D.	22c. DATE SIGNED 12/03/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter W. Yim MD.		22e. ADDRESS 7900 Old Branch Ave. Clinton Md. 20735	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/06/87	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Augusta Virginia
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.		25a. DATE REC'D. BY REGISTRAR DEC - 9 1987	25b. REGISTRAR'S SIGNATURE
6633 Old Alexander Ferry Road Clinton Md. 20735			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div>#12b,13abcde,per call 2/26/88 kalm</div> <div>REG. NO. 36645</div> </div>									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST BERTHA VIRGINIA McCORMICK			DECEMBER 16		1987		2:14 PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	April 4, 1893		94 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	U.S.A.			Prince George's MD.					
11. CITY OR TOWN OF DEATH	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	AMI Doctors' Hospital of Pr. Geo.			Co. Home Maker			Own Home		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.		Marion P.G.		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6511 Auburn Ave. 26564-20737	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Greenwood Powell			Elvira Kisner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
NO			233-62-4537			Virginia Walley/6511 Auburn Ave, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/87</u> 19 <u>87</u> , to <u>12/16/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/16/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Bertram Weisbaum</u> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bertram Weisbaum, M.D.				22e. ADDRESS 7500 Hanover Parkway, Greenbelt, Md. 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/21/87		Masonic Cemetery		Shinnston Harrison WVA			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harmer Fun. Hm., P.O. Box 1852, Shinnston, WVA				DEC 24 1987					

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075249 DEC 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36640

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>June N. McCune</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 12 87</i>		2b. HOUR MIN. <i>10 30</i>	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 18, 1923		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS MONTHS DAYS IF UNDER 1 YEAR IF UNDER 23 HRS.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6255 Oxon Hill Rd. #101 20745			
14. FATHER'S NAME FIRST MIDDLE LAST John C. Laick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie B. Fearer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 198-18-5962		17. INFORMANT ADDRESS Jerrold M. McCune 6255 Oxon Hill Rd. #101 Oxon Hill, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Terminal Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/13/87</i> to <i>12/12/87</i> , that (I) (we) last saw the deceased alive on <i>12/12/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)						
22b. SIGNATURE <i>Laxmi Berwa</i>				22c. DATE SIGNED 12.13.87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laxmi Berwa, M.D.				22e. ADDRESS 7700 Old Branch Ave., Clinton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/87		23c. NAME OF CEMETERY OR CREMATORY McClellandtown Ch. Cem. McClellandtown Penn.		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		6160 Oxon Hill Rd. ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 15 1987		
				25b. REGISTRAR'S SIGNATURE <i>Julia S. ...</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 REG. NO. 35647							
1. DECEASED NAME (FIRST, MIDDLE, LAST) ROBERT MCFADDEN					2a. DATE OF DEATH (MONTH, DAY, YEAR) 12-27-87			2b. HOUR 5.55P M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH (MONTH, DAY, YEAR) 7 22 05		6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Engineer		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. STATE Md.			13b. COUNTY Upper Marlboro		13c. CITY OR TOWN NO <input type="checkbox"/> YES <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 10805 Joyceton Ct. 20112		
14. FATHER'S NAME (FIRST, MIDDLE, LAST) James McFadden				15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-01-9965		17. INFORMANT ADDRESS Ms. Lualgia Watson/niece/same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cordiod respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis Right lower lobe pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/P Multiple CVA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>87</u> to <u>12/27</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DANIEL ORUTAS MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Orutas					22e. ADDRESS PG 6 H				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.		
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E., D.C.					25a. DATE REC'D. BY REGISTRAR 2001 JAN 4 1988				
					25b. REGISTRAR'S SIGNATURE				

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36648

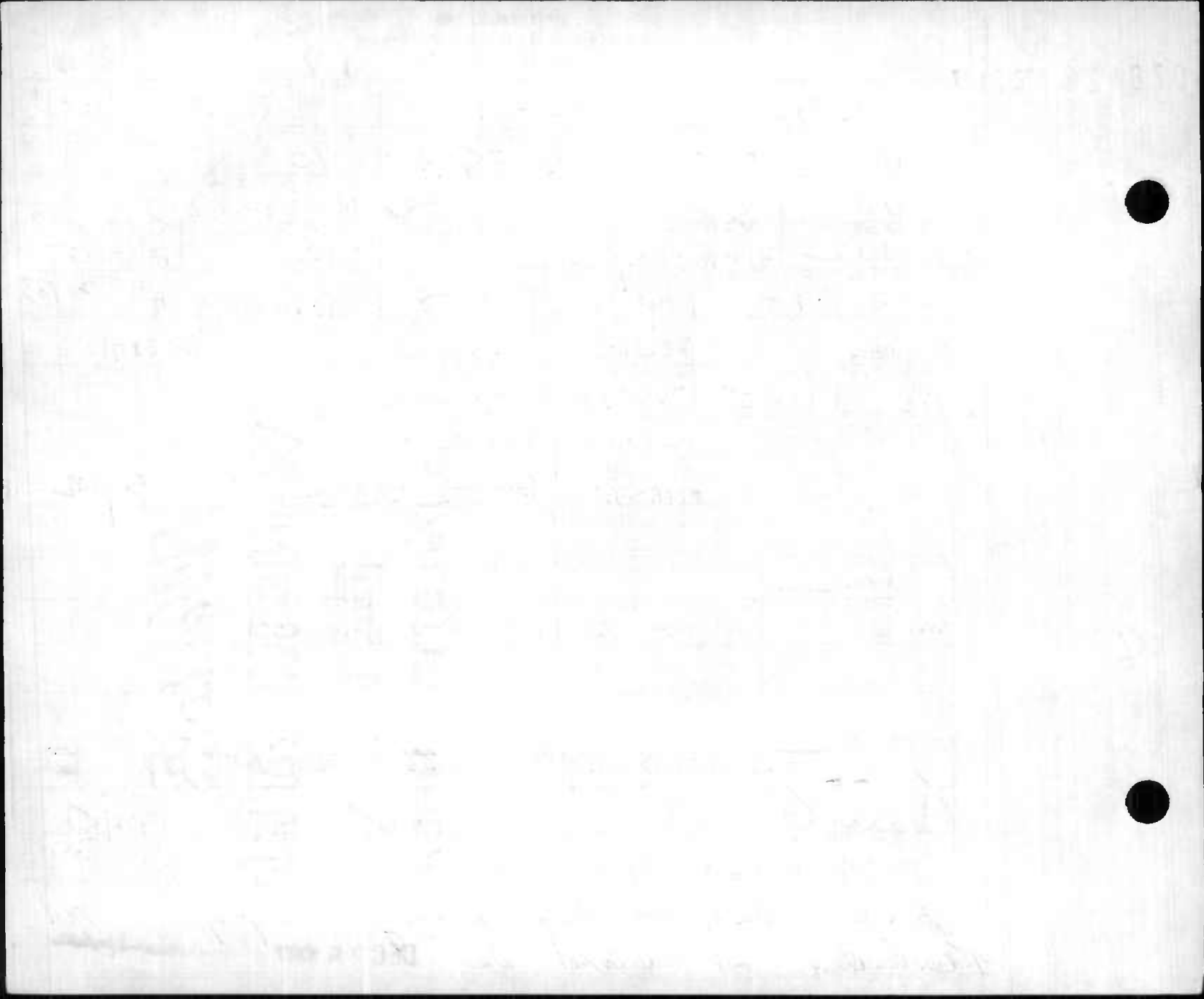
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PETER MICHAEL MEEHAN		2a. DATE OF DEATH MONTH DAY YEAR 12 25 87		2b. HOUR P M 1145 P	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6 25 14		6. AGE (IN YEARS LAST BIRTHDAY) 73 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH HYATTSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3110 ROSEMARY LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY PRINTING
13a. STATE MD		13b. COUNTY PGT.	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3110 ROSEMARY LN. 20783
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL MEEHAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINA MORRAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 065079518		17. INFORMANT ADDRESS CARL LANDI SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC PROSTATE CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SYEM</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u>					
19a. DATE OF OPERATION SEPT 87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (CRANIOTOMY - BRAIN METASTASIS)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. INJURY OCCURRED CITY OR TOWN COUNTY STATE		21g. LOCATION STREET			
22a. I certify that (I) (the hospital) attended the deceased from <u>SEPT 19 87</u> to <u>DECEMBER 25 19 87</u> , that (I) <u>lost</u> saw the deceased alive on <u>DECEMBER 18 19 87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>Thomas A. Tesoriero</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. TESORIERO, M.D.		22e. ADDRESS 1011 NORTH CAPITOL ST NE, WASH DC 20002			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD		23e. DATE REC'D. BY REGISTRAR DEC 28 1987			
24. FUNERAL DIRECTOR NAME Teresa Funerary		24b. ADDRESS 2511 Canal Dr NW DC		25. REGISTRAR'S SIGNATURE Chela Davidson-Rodriguez	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO. 35649

1. DECEASED NAME (TYPE OR PRINT) PAUL T. MESSINK			2a. DATE OF DEATH MONTH DAY YEAR DEC 24 87		2b. HOUR 1:35 PM
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 29 04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting		12b. KIND OF BUSINESS OR INDUSTRY Tobacco Co.
13a. STATE Virginia	13b. COUNTY Prince William	13c. CITY OR TOWN Dumfries	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 15891 Beaver Dam Rd. 22026	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Messink		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta A. himmelberg		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 577-07-0350		17. INFORMANT Kathleen A.S. Messink		ADDRESS 15891 Beaver Dam Rd. Dumfries, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STROKE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the deceased) attended the deceased from 6/5 19 87 , to 12 19 87 , that (we) lost saw the deceased alive on 12/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE James J. Foster		DEGREE Attending Physician		22c. DATE SIGNED 12/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. Foster		22e. ADDRESS 916 19th N.W. WASH D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/29/87	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.	
24. FUNERAL DIRECTOR NAME George p. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D BY REGISTRAR DEC 28 1987	
25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items, 18a, 21b.-22a., G-634, by Med. Ex. STATE OF MARYLAND
 FOR 12/21/87, Gbj.
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. REGISTRATION NO. 073343		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
7. NAME (TYPE OR PRINT)		8. FIRST		9. MIDDLE		10. LAST		11. REG. NO.		12. 5 5 4	
13. SEX		14. RACE		15. DATE OF BIRTH		16. AGE (IN YEARS)		17. IF UNDER 1 YR.		18. IF UNDER 24 HRS.	
Male		White		Nov 18, 1954		32 YRS.		MONTHS		DAYS	
19. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		20. CITIZEN OF WHAT COUNTRY?		21. MARRIED		22. NEVER MARRIED		23. WIDOWED		24. DIVORCED	
Washington DC		USA		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	
25. CITY OR TOWN OF DEATH		26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		27. BALTIMORE CITY OR COUNTY OF DEATH		28. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		29. KIND OF BUSINESS OR INDUSTRY		30. DATE	
Andrews AFB Md		Andrews Air Force Base Hosp.		Prince George's County MD		Rte Salesman		Bakery		11 17 87	
31. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		32. STATE		33. COUNTY		34. CITY OR TOWN		35. INSIDE CITY LIMITS?		36. STREET ADDRESS	
Maryland		Pr George		Forestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		37. 3305 Pinevale Ave		20747	
38. FATHER'S NAME		39. MOTHER'S MAIDEN NAME		40. FIRST		41. MIDDLE		42. LAST		43. ADDRESS	
Edwin Davis		Thuridur G. Arnadotter		Thuridur		G.		Arnadotter		Same as #13	
44. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		45. SOCIAL SECURITY NO.		46. INFORMANT		47. ADDRESS		48. DATE		49. TIME	
No		220-62-5870		Thuridur Mellen		Same as #13		11-18-87		4:17 PM	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Phencyclidine intoxication			
DUE TO, OR AS A CONSEQUENCE OF			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 17 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
				Subject used phencyclidine	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		found in car		3305 Pinevale Avenue, Forestville, P.G. Co., Maryland	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
		Deputy Chief		11-18-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE	
Ann M. Dixon, M.D.		111 Penn St., Balto., MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Cremation		Nov 21, 1987		Cedar Hill Crematory		Suitland PG Md		NOV 25 1987			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE		25d. TIME		25e. ADDRESS	
NAME										Funeral Home Suitland, Md	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

173613 019270

20% COTTON FIBER

EMERSON WINDMILL CO.



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO 35651

1. FOR STATE RECORD JAN 9 1988		2a. DATE OF DEATH MONTH DAY YEAR 12-22-87		2b. HOUR 12-55 PM
3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIN P MELVIN		4. SEX Male		5. RACE White
6. DATE OF BIRTH October 7 1930		7. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		9b. CITIZEN OF WHAT COUNTRY? USA		9c. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver
12b. KIND OF BUSINESS OR INDUSTRY Salesman		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY PR George
13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4005 Murdock St. 20748
14. FATHER'S NAME Harry		15. MOTHER'S MAIDEN NAME Laura		16. GRAHAM
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1952 1956 426-54-4764		17. INFORMANT Margaret P Melvin
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).		19. CAUSE OF DEATH insanition metastatic head & neck cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>Spring</u> to <u>87</u> , to <u>Dec 22</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>above</u> , (I) (we) did not see the body after death.		22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22c. DATE SIGNED 12/23/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID HAIDAK, M.D.		22e. ADDRESS 8926 Woodyard Road, Clinton MD
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 Dec 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery Cheltenham MD
23d. LOCATION CITY OR TOWN COUNTY		24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 4 1988
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE

New York, N.Y. 10017

October 11, 1967

Dear Mr. [Name]:

I am writing to you regarding the [Subject] which was discussed at the [Meeting] on [Date].

The [Subject] is of great importance to the [Organization] and we are very interested in your [Response].

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

I am sure that you will find this information of interest and I am sure that you will be able to provide us with the [Information] we need.

RELEASED TO FAMILY PHYSICIAN BY
DR. ROGERS, D.M.E. (P.G. COUNTY)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8736652
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hazel Irene MICHAELS			2a. DATE OF DEATH MONTH DAY YEAR December 19 1987		2b. HOUR 6:00 a.m.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 07-28-1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH College Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9014 Rhode Island Avenue, #408		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9014 Rhode Island Ave., #408 20740
14. FATHER'S NAME FIRST MIDDLE LAST George Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Wells			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 207-03-7364		17. INFORMANT 4901 Erie St., College Park, Mr. Clair E. Michaels, Maryland 20740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest, secondary to arrhythmia Sudden DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Non-insulin-dependent diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 25 March 1972 to 19 December 1987, that (I) (we) last saw the deceased alive on 7 December 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Carl J. Houmann</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 19 Dec. 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M. D.			22e. ADDRESS 4404 Queensbury Rd., Riverdale, MD 20737		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/87	23c. NAME OF CEMETERY OR CREMATORY Calvary U. Meth. Ch. Cem. Wiconesco, Dauphin, Pa.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR FRANCIS GASCH'S SOSN FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland			25. DATE REC'D. BY REGISTRAR DEC 24 1987		

SECRET



MEDICAL CERTIFICATION

DHMH 17
(VR A15 ME (5))



077784 JAN 12 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36654

1. DECEASED'S NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Patricia T		Miles		12-25-87		6:55 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
F	Black	Feb. 24, 1951		36		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia	U. S. A.			PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Polinton	SOUTHERN MD HOSP CENTER		Exec. Assistant		Engineering		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland	Pr. Georges	Ft. Washington		2002 Brierhill Rd 20744			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Raymond XXXXXX V. Taylor, Jr.		Juanita Cephes Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		226-72-4141		Wayne Eric Miles 2002 Brierhill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic pancreatic cancer</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) <u>malignant ascites</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>11a</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 27, 87</u> to <u>Dec 25, 87</u> , that (I) (we) last saw the deceased alive on <u>Dec 25, 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
D.J. HAYDAK		MD				12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
D.J. HAYDAK		Clinton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/31/87		Oakwood Cemetery		Richmond, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Scott's Scott's Funeral Home - Richmond, Va.				JAN 11 1988		W. A. Anderson-Radner	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and medical examiner, a medical examiner must be notified of this.

077307 JAN 7 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36655

FOR 1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Evelyn Colonia MILLER		Female		Black	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
07 27 30		57 YRS.		West Virginia	
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A.				Prince George's MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Lanham		AMI DOCTORS' HOSPITAL OF PR. GEO. CO		Clerk	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
Private		2001 28th St. S.E., #303		Washington	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Robert Lee Anthony		Colonia Evelyn Hairston		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
234-40-9227		Reginald Miller Washington, D.C.		(a) IMMEDIATE CAUSE (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF	
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, and that on (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D BY REGISTRAR	
Lewis H. Dennis, M.D.		Suite U-17		JAN 6 1988	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Dec 23 1987		Lincoln Mem. Cem. Suitland, MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart Funeral Home 4001 Benning Rd. NE		JAN 6 1988		Julia Davidson	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 5 5 0

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
George Miller Sr.

2b. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 12-18 87 2b HOUR M

1. SEX

male

4 RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR Aug 3 1949

6. AGE (IN YEARS)

LAST BIRTHDAY 38 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR 12-18 87 2d HOUR M 3:17

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED

WIDOWED ☐ NEVER MARRIED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges MD

10. CITY OR TOWN OF DEATH

Cap. Hgts

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1225 Benning Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Stock Clerk

12b. KIND OF BUSINESS OR INDUSTRY

Airport

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

D.C.

13b. COUNTY

Washington

13c. CITY OR TOWN

Washington

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3954 Clay Place N.E.

14. FATHER'S NAME

George

MIDDLE

Miller

LAST

Miller

15. MOTHER'S MAIDEN NAME

Wilhelmina

MIDDLE

Brown

LAST

Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

N/A

17. INFORMANT

577-64-3964

17. ADDRESS

Wilhelmina James 1225 Benn. Rd. cap Hgts md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

12-18-87

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-23-87

23c. NAME OF CEMETERY OR CREMATORY

Harmony Cemetery

23d. LOCATION (CITY OR TOWN)

Landover

COUNTY

P.G.

STATE

md.

24. FUNERAL DIRECTOR

NAME

Comer-Hodges 4901 Marlboro Pike

ADDRESS

Coral Hills md.

25a. DATE REC'D. BY REGISTRAR

JAN 7 1988

25b. REGISTRAR'S SIGNATURE

Julie Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PMA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO. 87 36657

073814 DEC - 1987

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST **HAZEL P. MILLER**

3. SEX **Female**

4. RACE **Cauc.**

5. DATE OF BIRTH MONTH DAY YEAR **7 1 18**

6. AGE (IN YEARS LAST BIRTHDAY) **69** IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Tenn.**

7b. CITIZEN OF WHAT COUNTRY? **USA**

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH **Prince Georges Co. MD**

10. CITY OR TOWN OF DEATH **CLINTON**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **So. Maryland Hospital**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Homemaker**

12b. KIND OF BUSINESS OR INDUSTRY **at home**

13a. STATE **Maryland**

13b. COUNTY **Pr. George**

13c. CITY OR TOWN **Ft. Washington**

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE **1601 Tucker Rd. 20744**

14. FATHER'S NAME FIRST MIDDLE LAST **Landon J. Cole**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Fannie Matilda Scalf**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **no** (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO. **579-24-6040**

17. INFORMANT ADDRESS **Ivan R. Miller same as item 13**

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Respiratory arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) **Terminal Lung Cancer**

DUE TO, OR AS A CONSEQUENCE OF (c) **Pleural effusion**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **11/30/87** to **12/1/87**, that (I) (we) last saw the deceased alive on **11/30/87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **L. Betwa** DEGREE **MD**

22c. DATE SIGNED **12.1.87**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **L. BETWA**

22e. ADDRESS **1300 MERCANTILE LANE LANDOVER MD 20785**

22f. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial**

23b. DATE **12/3/87**

23c. NAME OF CEMETERY OR CREMATORY **Ft. Lincoln Cemetery**

23d. LOCATION CITY OR TOWN COUNTY STATE **Brentwood P.G. Md.**

24. FUNERAL DIRECTOR NAME ADDRESS **G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.**

25a. DATE REC'D. BY REGISTRAR **DEC 02 1987**

25b. REGISTRAR'S SIGNATURE **Alia Dandrea-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (written).

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this and other papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

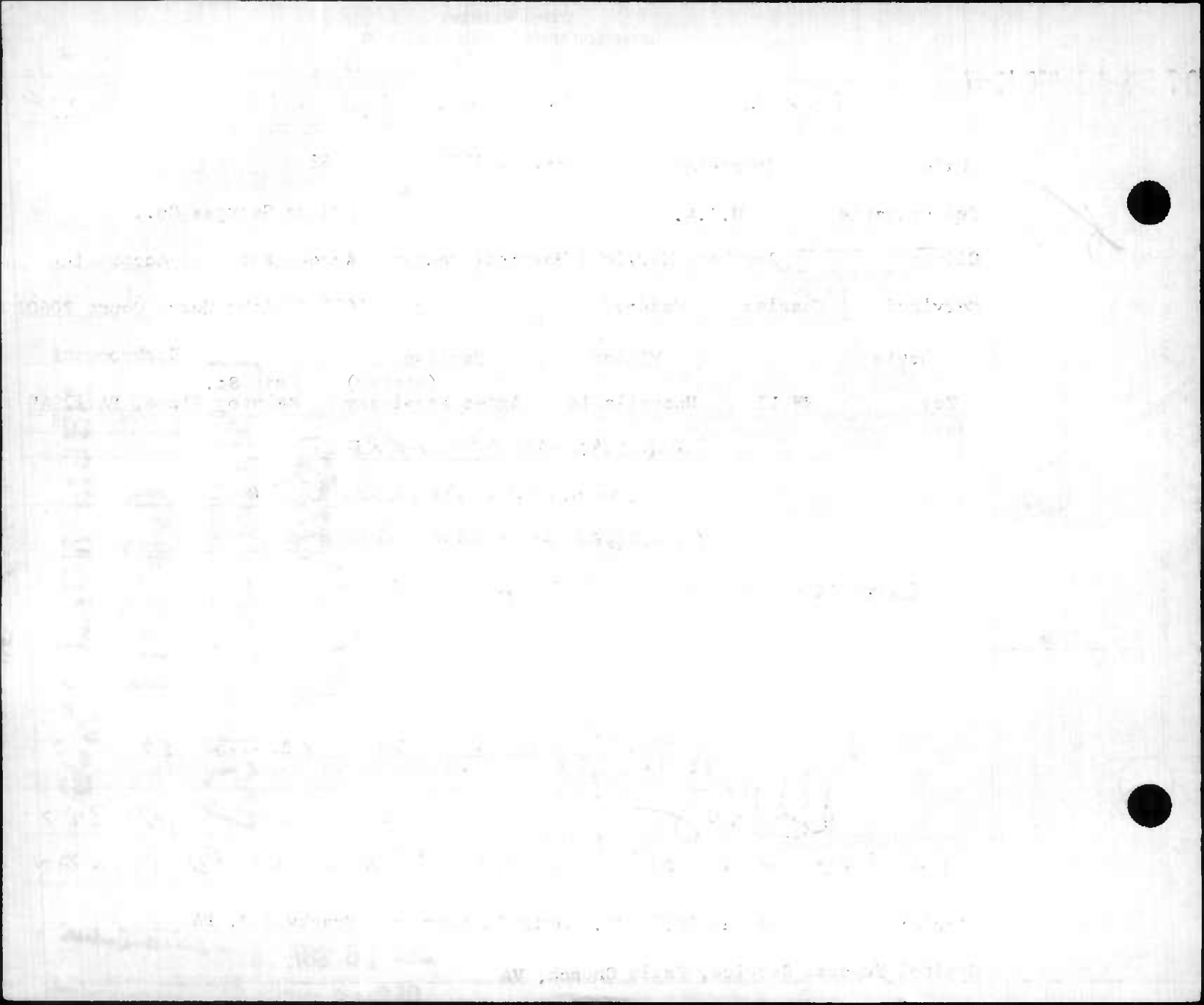
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified immediately.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36658

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH MILLER			2a. DATE OF DEATH MONTH DAY YEAR 12-12-87		2b. HOUR 120 P						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Mar. 7, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co., MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Accounting			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4007 C Night Heron Court 20601			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Dombrowski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT (sister) Agnes Naspinsky		ADDRESS Main St. Mahanoy Plane, PA 17949					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CEREBROVASCULAR DISEASE.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHOLECYSTECTOMY CARDIAC ARRHYTHMIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from 12-8, 1987 , to 12-12, 1987 , that (b) (we) last saw the deceased alive on 12-12, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Samtani				DEGREE MD FACC		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-13-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ SAMTANI MD FACC				22e. ADDRESS 9131 PISCATAWAY RD CLINTON							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16 Dec 1987		23c. NAME OF CEMETERY OR CREMATORY St. Louis Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frackville, PA					
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service, Falls Church, VA				25. DATE REC'D. BY REGISTRAR DEC 16 1987		26. REGISTRAR'S SIGNATURE John J. [Signature]					



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36659

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSABET Elizabeth MILLER			2a. DATE OF DEATH MONTH DAY YEAR 12 27 87			2b. HOUR M 12:15A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 23 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14200 Laurel Park Drive 20707	
14. FATHER'S NAME FIRST MIDDLE LAST Marvin Munger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgie Surber						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) n/a		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT 9721 Murkirk Rd. Molly Hawkins Laurel, Md. 20708					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 11 19 87, to 12/27 19 87, that (I) (we) last saw the deceased alive on 12/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22a. SIGNATURE GREGORY A. COMPTON						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A. COMPTON						22e. ADDRESS 2317 CHERRY LN. Laurel Md 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/87		23c. NAME OF CEMETERY OR CREMATORY Monocacy Gemetery		23d. LOCATION Beatsville Mont. Md.		
24. FUNERAL DIRECTOR NAME 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707						25a. DATE REC'D BY REGISTRAR JAN 4 1988			
25b. REGISTRAR'S SIGNATURE									

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36660

1. DECEASED NAME (TYPE OR PRINT) Iris Jenerieve Minnix			2a. DATE OF DEATH MONTH DAY YEAR December 7, 1987		2b. HOUR 11:45 AM
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR July 31, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hosp. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN District Hgts	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Mack		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Young		13e. STREET ADDRESS / ZIP CODE 2305 Senator Avenue 20747	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ----- 235-20-4856		17. INFORMANT ADDRESS 391 Valley Oak Ct. Waldorf, Md. 20601	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>alzheimer's disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> a) HEIRK b) WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <u>4-8</u> , 19 <u>86</u> , to <u>12-7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>William Kent Furst</u>		DEGREE MD	22c. DATE SIGNED Dec. 8, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William K. Furst, M D		22e. ADDRESS 11701 Livingston Road #101 Ft. Washington, Md. 20744	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE (SPECIFY) Dec. 10, 1987	23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Mem. Cem. Phillippi, Barbour, W. Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 09 1987	
P.O. BOX 156 Waldorf, Md. 20601		25b. REGISTRAR'S SIGNATURE <u>John Darden</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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COTTON

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36661

FOR 1. STATE REGISTRAR		2. DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 26 87		830 ^{PM}	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		Black		5 11 22		65 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Wash. D.C.		U.S.A.				Prince Georges MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Riverdale		Leland Memorial Hospital		Domestic		Private	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland		P.G.		Suitland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
William H. Sharpe		Alberta Francis Woodland		No		N/A 579-26-4967	
17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
Kenneth Mitchell-4810 Bennett Ave.		Cardiopulmonary Arrest Septic Shock; Peritonitis Resection of Gangrenous Bowel Acute Renal Failure		12/24/87		Bowel obstruction; Gangrenous Small Bowel	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/>		HOUR A.M. MONTH DAY YEAR P.M. 19	
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION		21g CITY OR TOWN	
WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12-22-1987 to 12-26-1987 that (I) (we) last saw the deceased alive on 12-26-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT)	
		T. M. D. (Signature)		M.D.		S. M. D. (Signature)	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial		Dec. 31, 1987		Cedar Hill Cem.		Suitland, MD.	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c ADDRESS	
John T. Stewart III		JAN 6 1988		Julia Borden (Signature)		6510 Kenilworth Ave Riverdale M.D. 20737	
25d ADDRESS		25e DATE REC'D. BY REGISTRAR		25f REGISTRAR'S SIGNATURE		25g ADDRESS	
Stewart Funeral Home 4001 Benning Rd. NE		JAN 6 1988		Julia Borden (Signature)		6510 Kenilworth Ave Riverdale M.D. 20737	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

075584 DEC 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 15 6 0 2

1- STATE REGISTRAR												2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR							
DECEASED NAME (TYPE OR PRINT) <i>Viola Frances Moore</i>												ESTIMATED <input checked="" type="checkbox"/> 12-11		19 87		AM							
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1/24/22</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>65 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>12-11</i>		19 87		2d. HOUR							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>				MD.							
10. CITY OR TOWN OF DEATH <i>Clinton</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>waitress</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>food</i>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE <i>Maryland</i>		13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Forestville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3520 Pinevale Avenue</i>		20747	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Anthony Gagar</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Stablum</i>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>						16b. SOCIAL SECURITY NO. <i>234-32-6066</i>		17. INFORMANT ADDRESS <i>Harold A. Moore same as #13</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Centurium</i> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Anti coagulant regimen</i>																							
19a. DATE OF OPERATION <i>12-11-87</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>cerebral hemorrhage</i>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8 P.M. 12-9 19 87</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Fell back wards @ home while walking</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3520 Pinevale Ave., Forestville, Prince Georges, MD</i>															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED <i>12-12-87</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>12/14/87</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Mt Carmal Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Upper Marlboro PG MD</i>											
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>				ADDRESS <i>Funeral Home</i>				25. DATE REC'D. BY REGISTRAR <i>DEC 18 1987</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

128
A

DEC 18 1981

074739 DEC 11 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Henry Moos					2a. DATE OF DEATH December 3, 1987		2b. HOUR 10:30am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-14-1906		6. AGE (IN YEARS (LAST BIRTHDAY)) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9014 Rhode Island Ave. 20740	
14. FATHER'S NAME Henry Moos				15. MOTHER'S MAIDEN NAME Agnes May Cook						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 136-16-9033		17. INFORMANT Harvey James, Jr.		ADDRESS 6916 Nashville Rd. Lanham, Maryland 20706				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Three days</u> <u>Unknown</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Renal failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>September 14, 1974</u> to <u>December 3, 1987</u> , that (I) (we) lost saw the deceased alive on <u>December 3, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Carl J. Houmann</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M.D.				22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20737						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland				
24. FUNERAL DIRECTOR Donald Borgwardt				4400 Powder Mill Road Beltsville, Md. 20705		25a. DATE REC'D. BY REGISTRAR DEC 10 1987		25b. REGISTRAR'S SIGNATURE <u>J. E. Kridner</u>		

IN SENATE
January 11, 1906
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1905
ALBANY:
J. B. LEECH, STATE PRINTER
1906

077783 JAN 12 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be detached for use as the burial-transit permit. Then please remove contents of this page and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) THEODORE E. MORGAL					2a. DATE OF DEATH MONTH DAY YEAR 12/31/87		2b. HOUR MIN. 11:30 P		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3- 23- 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman- Wash. Gas Light Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN District Hgts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7002 Gateway Blvd. 20747	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrance L. Morgal		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace E. Hatfield		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					
16b. SOCIAL SECURITY NO. 458-38-3620		17. INFORMANT ADDRESS Gerald W. Morgal Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 1987 to 12/31 1987 that (I) (we) lost saw the deceased alive on 12/31 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harvey Kattan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-1-88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY KATTAN				22e. ADDRESS 8926 WOODWARD Rd Clinton MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-1988		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home				6633 Old Alexander Ferry Clinton, Md.		25a. DATE REC'D. BY REGISTRAR JAN 11 1988		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

075264 DEC 16 87

DECEASED NAME (TYPE OR PRINT) **SAVARHETT** FIRST **SAVARHETT** MIDDLE LAST **MORSE SR.**
Morse

2a. DATE OF DEATH MONTH **DEC.** DAY **8** YEAR **1987** 2b. HOUR **17:35** M

3. SEX **MALE** 4. RACE **NEGRO** 5. DATE OF BIRTH MONTH **7** DAY **30** YEAR **10** 6. AGE (IN YEARS LAST BIRTHDAY) **77** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **SPARTA, GEORGIA** 7b. CITIZEN OF WHAT COUNTRY? **U.S.A.** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **PRINCE GEORGES COUNTY MD**

10. CITY OR TOWN OF DEATH **TAKOMA PARK, MD.** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **WASHINGTON ADVENTIST HOSPITAL** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **MINISTER** 12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE **MARYLAND** 13c. CITY OR TOWN **LAUREL** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE **11731 SOUTH LAUREL DRIVE APT. 612 A**

14. FATHER'S NAME FIRST **RICHARD** MIDDLE LAST **MORSE** 15. MOTHER'S MAIDEN NAME FIRST **MAMIE** MIDDLE LAST **D. MORSE**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **No** (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. **083-01-3541** 17. INFORMANT ADDRESS **1173 SOUTH LAUREL DRIVE LAUREL, MARYLAND.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) inertness

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) metastatic lung cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. **19** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from Dec 8 1987 to Dec 8 1987 that I saw the deceased alive on above, (2) (I did) (I did not) view the body after death. 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE D. J. Haidale M.D. DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 12/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. J. HAIDALE 22e. ADDRESS Clinton, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL** 23b. DATE **12-12-1987** 23c. NAME OF CEMETERY OR CREMATORY **FT. LINCOLN** 23d. LOCATION CITY OR TOWN COUNTY STATE **BLADENSBURG P.G. MARYLAND.**

24. FUNERAL DIRECTOR W.H.B. ACON FUNERAL Edwards W. Jones WASH. DC. DATE REC'D. BY REGISTRAR DEC 15 1987 REGISTRAR'S SIGNATURE Julia Davidson-Pandell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

93-21 379 1 2 3 2 7 0

075655 DEC 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5560

1- STATE REGISTRAR		FOR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
Edward Jones			
2a. DATE KNOWN OF DEATH		MONTH	DAY
12-14-87			
2b. HOUR		M	
3. SEX		4. RACE	5. DATE OF BIRTH
MALE		WHITE	MONTH DAY YEAR
			SEPT. 14, 1920
6. AGE (IN YEARS LAST BIRTHDAY)		7. AGE (IN YEARS LAST BIRTHDAY)	8. YRS.
67			
9. IF UNDER 1 YR.		10. IF UNDER 24 HRS.	11. DATE PRONOUNCED DEAD
MONTHS		DAYS	HOURS
			12-14-87
12. DATE PRONOUNCED DEAD		13. HOUR	
		2:20 PM	
14. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		15. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Cheverly		Prince George's General Hospital	
18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		19. KIND OF BUSINESS OR INDUSTRY	
TRUCK DRIVER		TRANSFER CO.	
20. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		21. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
13a. STATE		13b. COUNTY	
MARYLAND		ST. MARY'S	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
HOLLYWOOD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS		13f. STREET ADDRESS	
RT. #1, BOX 73		20636	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
PAUL JOY MOSHER		LIDA ESTER JONES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		219-16-1991	
17. INFORMANT		18. ADDRESS	
MRS. FAY DEAN		RT. #2, BOX 63	
		HOLLYWOOD, MARYLAND 20636	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) Multiple injuries		
DUE TO, OR AS A CONSEQUENCE OF		
(b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		
		1:15 PM 12-14-87		Driver in truck/truck collision
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		road		Thompson Corner Rd. & Rt. 15, New Market, ST. MARY'S COUNTY, MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Charles P. Kokes, M.D.		Assistant		12-15-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Charles P. Kokes, M.D.		111 Penn street, Baltimore, MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		12/18/87		JOY CHAPEL		HOLLYWOOD, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		DATE REC'D. BY REGISTRAR	
EDWARD N. BRINSFIELD, JR.,		LEONARDTOWN, MD.				DEC 21 1987	
						REGISTRAR'S SIGNATURE	
						Julia Swisher-Rodman	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))

072-32-1234

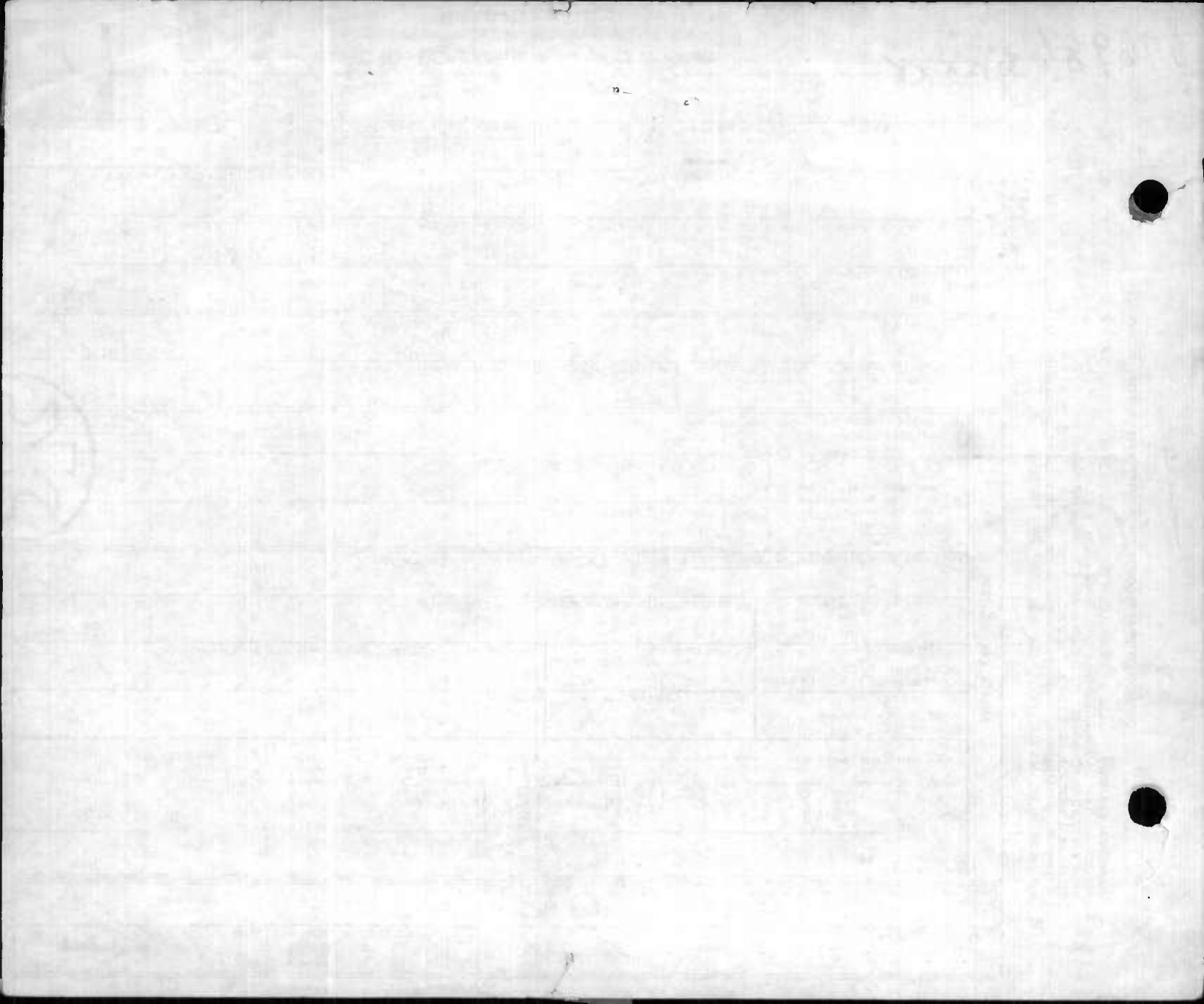
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5 6 6 8

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD		
FIRST MIDDLE LAST Havold I Moyer			MONTH DAY YEAR Dec 28 1987			MONTH DAY YEAR Dec 28 1987			HOUR MIN 12 00		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.						
M	W	MONTH DAY YEAR Sept 5 1961	LAST BIRTHDAY YRS.	MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA			USA						Prince Georges MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Riversdale			Lealand Mem Hosp			CAPTAIN			AIR FORCE		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD			Prince Georges			Hyattsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST ROY MOYER			FIRST MIDDLE LAST IRENE HOPKINS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			1940-1961			406-14-9846			DOROTHY E. MOYER/WIFE/SAME AS 13		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)		
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		
(b) Chronic Myocardial Dis		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers		M.D. Dep		Dec 28 1987	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
JOHN S. ROGERS		SEMINARY SILVER SPRING, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	DEC 31, 1987	ARLINGTON NATL CEMETERY	ARLINGTON VIRGINIA
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS, JR.		JAN 4 1988	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25b. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINT IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36559

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA A. MUELLER			2a. DATE OF DEATH MONTH DAY YEAR 12 23 87		2b. HOUR 7:30p M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS HOURS MIN. 0 0	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		13. BALTIMORE CITY OR COUNTY OF DEATH PRINCE-GEORGES COUNTY MD.	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE Maryland		14b. COUNTY Calvert		14c. CITY OR TOWN Dunkirk		14d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14e. STREET ADDRESS / ZIP CODE 1821 Inverness Way 20754			
15. FATHER'S NAME FIRST MIDDLE LAST Clement LeBlanc		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Cormeir		17. INFORMANT (Grandson) John C. Remson, Jr.		18. ADDRESS 1821 Inverness Way Dunkirk, Md. 20754					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		19b. SOCIAL SECURITY NO. 154-18-0374		19c. DATE OF DEATH 12/23/87		19d. TIME OF DEATH 7:30p		19e. PLACE OF DEATH CLINTON		19f. COUNTY OF DEATH PRINCE-GEORGES	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) LIVER CELL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SEPTICEMIA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Leukemoid reaction; renal failure.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/23/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6 Post Office Road, Waldorf MD 20601	
22a. I certify that (I) (this hospital) attended the deceased from 12/15/87 to 12/23/87 , that (I) (we) lost saw the deceased alive on 12/23/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Goncalves		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED DEC 31 1987							
23a. PHYSICIAN'S NAME (TYPE OR PRINT) A. GONCALVES		23b. ADDRESS 6 Post Office Road, Waldorf MD 20601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR DEC 31 1987		25b. REGISTRAR'S SIGNATURE John C. Remson, Jr.							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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075657 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HILDA		12:00 AM. 12 15 87		1:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Caucasian	3 1 1913	74	Prince George's	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Scaggsville, Md.	USA		Waitress		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
Laurel	Greater Laurel Beltsville Hosp.	Rest. (Ret)		9040 Cherry Lane 20708	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.	P.G.	Laurel	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9040 Cherry Lane 20708	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
William R. Murphy, Sr.	Addie Miles	n/a			
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
213-05-1936	Katherine Whitmer	887 IMMEDIATE CAUSE (a) Respiratory failure			
	Odenton, Md. 21113	(b) Carcinoma of Rt lung -			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Fractured ribs (left) Pneumonia of lung -					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		22c. DATE SIGNED	
	HOUR A.M. MONTH DAY YEAR			12-15-87	
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE		G.A. DELATORRE, MD	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22e. ADDRESS	
Nov 2, 19 87, to Dec. 14, 19 87, that (I) (we) last saw the deceased alive on Dec. 14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.		DEGREE MD		320 Montgomery St. Laurel, Md. 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	25a. DATE REC'D. BY REGISTRAR
Burial	12/18/87	St. Paul's Cemetery	Fulton	Howard Md.	DEC 21 1987
24. FUNERAL DIRECTOR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
7601 Sandy Spring Road		Fleck Funeral Home, Inc. Laurel, Md. 20707		J. A. Smith, Registrar	

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REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36671

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARGARET MURPHY			MONTH DAY YEAR DEC. 21 1987			10:40AM		
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	CAUC.	MONTH DAY YEAR AUGUST 29, 1897		90 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
WISCONSIN	USA				PRINCE GEORGES MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
ADELPHI	9203 TUCKAHOE LANE			SECRETARY		PATIENT OFFICE		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND			PR GEORGES		ADELPHI		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST JOSEPH F. HORNING			FIRST MIDDLE LAST MARY ANN DEERY		9203 TUCKAHOE LANE 20783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			579-40-0194		EILEEN ZBIGNIEWICH/DAUGHTER/SAME AS 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>spinal Cord Degeneration</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Decubiti</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
						82 21 Dec 87		
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Merton L. White			M.D.			21 Dec 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
DR. MERTON WHITE			9911 GA. AVE. SILVER SPRING, MD. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY	
BURIAL			DEC 24, 1987		GATE OF HEAVEN CEM		SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS, JR.			DEC 24 1987					
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901								

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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25 x 25 (and 1 1/2 x 1 1/2)

Box 1

Box 1

Box 1

Box 1

014200 DEC-08

20X2 COLLOIDAL LAYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36573

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY EDNA NADER			2a. DATE OF DEATH MONTH DAY YEAR 12-08-87		2b. HOUR 11:30 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1929		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 58 YRS MONTHS DAYS HRS MIN		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Specialist			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Landover	
14. FATHER'S NAME FIRST MIDDLE LAST James Thomas Jenkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ever Tumblin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-32-8160		17. INFORMANT ADDRESS Henry W. Nader, Same as Line #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9. 8. 19 87</u> to <u>12. 8. 19 87</u> that (I) (we) last saw the deceased alive on <u>12. 7. 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>V. P. Singh</u>		DEGREE M.D.		22c. DATE SIGNED 12. 8. 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. P. SINGH		22e. ADDRESS 5632 ANNAPOLIS RD #9 BLADENSBURG MD 20710				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 12, 87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland		24. FUNERAL DIRECTOR FRANCIS GASCHS SONS FUNERAL HOME, PA. 4739 Baltimore Ave., Hyattsville, Maryland				
25a. DATE REC'D BY REGISTRAR DEC 17 1987				25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>		

BP

7-151 07/27/0

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6674

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED DEAD			2d. HOUR M		
FIRST MIDDLE LAST Roger William Neilan			3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 11/14/26			6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unityville, S. D.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			10. CITY OR TOWN OF DEATH Clinton		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Eastman Kodak			13a. STATE Maryland			13b. COUNTY P. G.		
13c. CITY OR TOWN Upper Marlboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 10910 Brookwood Ave.			20772			14. FATHER'S NAME FIRST MIDDLE LAST Ralph E. Neilan		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna J. Block			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes 1950-1951			16b. SOCIAL SECURITY NO. 318-22-5493			17. INFORMANT ADDRESS Anna Neilan Same as 13 A-E			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoraco-abdominal injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 PM 12-28-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in auto/auto collision	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Route 301, 12000 Block S. of Cherry Tree Crossing Rd. Prince Georges County, MD	

22a. I certify that I am in charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Charles P. Kokes* TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-29-87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince George's Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 8633 Old Alexander Ferry Rd Clinton, Md 20735				25a. DATE REC'D. BY REGISTRAR DEC 31 1987			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

7012000 35 37 0

WINTER
FARM COTTON B&B



Dec 21 1900

0754 12 DEC 18 87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR 2/24/88 cd1 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 12 1987 2b. HOUR 12:14 PM									
1 DECEASED NAME FIRST MIDDLE LAST LOUISE R. NELSON									
3 SEX Female 4 RACE Black 5 DATE OF BIRTH MONTH DAY YEAR 10/30/1959 6 AGE (IN YEARS) 28 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD									
10 CITY OR TOWN OF DEATH Riverdale 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b KIND OF BUSINESS OR INDUSTRY									
13a STATE Maryland 13b COUNTY Prince George 13c CITY OR TOWN Hyattsville 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 3201 Toledo Place									
14 FATHER'S NAME FIRST MIDDLE LAST Charles Coleman 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Jordan									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b SOCIAL SECURITY NO. 226-90-7205 12 INFORMANT ADDRESS Hyattsville, Md. Kenneth Nelson 3201 Toledo Place									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER DATE SIGNED 12-13-87									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial 23b DATE 12-17-87 23c NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery 23d LOCATION CITY OR TOWN COUNTY STATE Stafford County, Virginia									
24 FUNERAL DIRECTOR Bailey Funeral Service 1207 White Street Fredericksburg, Va 22401 25a DATE REC'D. BY REGISTRAR 17 1987 25b REGISTRAR'S SIGNATURE [Signature]									

75112100100



[Handwritten signature]

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 35670

1. DECEASED NAME (TYPE OR PRINT) Harry Douglas Newman			2a. DATE OF DEATH MONTH DAY YEAR 12-17-87			2b. HOUR 6:00 P.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1-1-12		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4521 Banner St., N. Brentwood 20722	
13a. STATE Maryland		13b. COUNTY Prince G.		13c. CITY OR TOWN Riverdale			
14. FATHER'S NAME FIRST MIDDLE LAST Henry D. Newton Newman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-40-7350		17. INFORMANT ADDRESS N. Brentwood, Md. 20722 James C. Smith/nephew/4521 Banner St.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia, congestive heart failure.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> , 19 <u>87</u> , to <u>12-17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>examine the body after death.</u>							
22b. SIGNATURE <u>Richard J. Feldman</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-18-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard J. Feldman</u>				22e. ADDRESS <u>9500 Arroyo Rd, LANHAM MD</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 23 December 1987		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN Suitland, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR McGuire Funeral Service, Inc, ADDRESS 7400 Georgia Ave N.W. DC 20012				25a. DATE REC'D. BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE <u>John E. Anderson</u>	

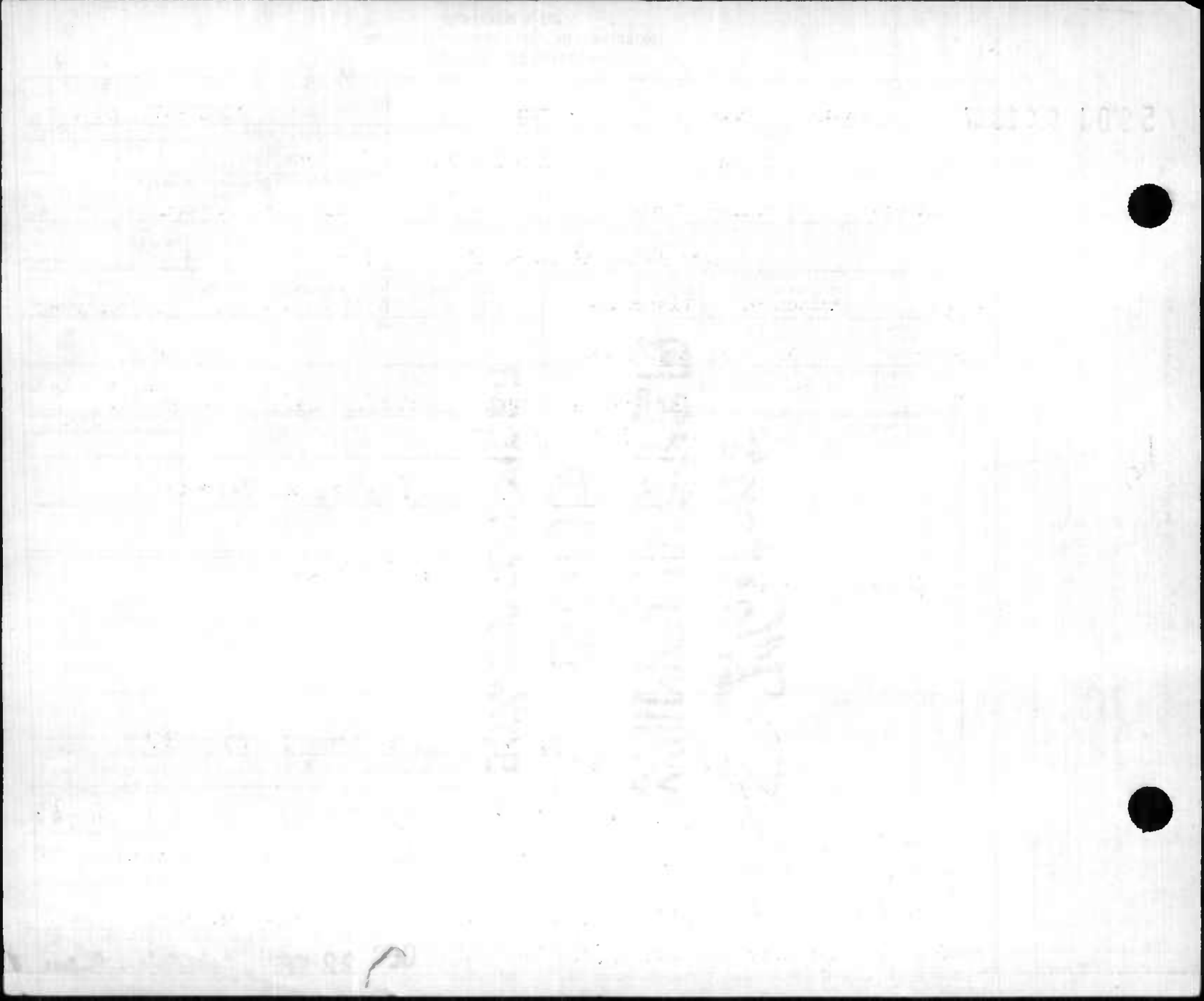
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

75990

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36677

FOR 1- STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) Eleanor Florence Nielsen		12		3	87	8	PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 18 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD			
10. CITY OR TOWN OF DEATH Upper Marlboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9702 Tiberias Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Lannan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Adams		13e. STREET ADDRESS / ZIP CODE 9702 Tiberias Drive 20772			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-18-6579		17. INFORMANT Gilbert Nielsen		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min.
DUE TO, OR AS A CONSEQUENCE OF (b) Jakob-Cretzfeld disease							5 mos.
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1971 19 to 3 Dec 1987, that (I) (we) last saw the deceased alive on 3 Dec 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Walter B. Sheer MD						22c. DATE SIGNED 3 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter B. SHEER MD						22e. ADDRESS 6400 Marlboro Pike District Heights, Maryland 20747	
23a. BURIAL, CREMATION, REMOVAL SPECIFY Cremation		23b. DATE 6 Dec 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

075000 DEC 1951

Elmer F. Nelson

12 3 37 19

3 min.

John-Crested 2 min.

3 Jan 52

Walter B. SHEPARD

Cemetery

075257 DEC 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36678

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
HUBERT W ESLEY NORMAN					DECEMBER	7	1987		10:25 ^A
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 74 HRS.	
MALE	WHITE	MONTH DAY YEAR AUG. 8, 1922			65	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
WISCONSIN	U.S.A.				Prince George's MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham	AMI Doctors' Hospital of Pr. Geo.			Co GEOLOGIST		SECURITY AND EXCHANGE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7903 MANDAN RD. #103 20770					
Ma.	P.G.C.	GREENBELT							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS					
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST				
CHESTER	ARTHUR	NORMAN	ETHEL	DANIELSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		22. RIDGE RD. #219 GREENBELT, Md. 20770			
YES		WWII		BETTY M. NORMAN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>87</u> to <u>12/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. GHOSH M.D.</u>				22e. ADDRESS <u>6510 KENILWORTH AVE. #1400 RIVERDALE MD 20737</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
CREMATION		12-8-1987		CHAMBERS CREMATORY		RIVERDALE,		P.G.C.	Ma.
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO.				RIVERDALE, Md. 20737		DEC 15 1987		<u>[Signature]</u>	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07 FEB 1970

U.S. AIR FORCE
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20330
ATTENTION: THE ADJUTANT GENERAL
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20330

U.S. AIR FORCE
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20330
ATTENTION: THE ADJUTANT GENERAL
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U.S. AIR FORCE
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ATTENTION: THE ADJUTANT GENERAL
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20330

077666 JAN 1 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36679
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY L. OSBORNE			2a. DATE OF DEATH MONTH DAY YEAR 12-22-87		2b. HOUR 730 P.M.	
3. SEX FEMALE	4. RACE BLK.	5. DATE OF BIRTH MONTH DAY YEAR 10-2-09		6. AGE (IN YEARS LAST BIRTHDAY) 78		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AMELIA Co. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE Co. MD		
10. CITY OR TOWN OF DEATH CHATHSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINE OPERATOR		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Washington D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN Washington D.C.		
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Scruggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Davy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 578-10-3222		17. INFORMANT ADDRESS William Osborne/113 Madison St., N.W. DC 20011				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiorespiratory failureAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Senile Dementia Alzheimers Type**years**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **3/20/55** to **12/22/87**, that (I) (we) last
saw the deceased alive on **12/17/87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/22/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

PAUL A. DEVORE M.D.

22e. ADDRESS

**4203 QUEENSWAY RD
HYATTSVILLE MD 20781**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE

29 December 1987

23c. NAME OF CEMETERY OR CREMATORY

Lincoln Memorial

23d. LOCATION

Suitland, Md.

COUNTY STATE

24. FUNERAL DIRECTOR

McGuire Funeral Serv., Inc.

7400 Georgia Ave., NW

Wash., D.C. DC

DATE REC'D. BY REGISTRAR

7 1988

25b. REGISTRAR'S SIGNATURE

via Davidson-Randall

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B (PAGE 1, 2, AND 3) TO THE FUNERAL DIRECTOR. THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5050

1. DECEASED NAME (TYPE OR PRINT) <i>June Wyant</i>		MIDDLE <i>Osti</i>		LAST <i>Osti</i>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>12 12 87</i>		2b. HOUR N	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 8 1920</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>67 YRS.</i>	7. IF UNDER 1 YR. MONTHS DAYS <i>12 12 87</i>	8. IF UNDER 24 HRS. HOURS MIN. <i>12 50 PM</i>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>12 12 87</i>		2d. HOUR PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>			
10. CITY OR TOWN OF DEATH <i>Ft. Washington</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1905 Border Drive</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Accountant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>E.B.Osti Co.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>Ft. Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1905 Border Dr. 20744</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Orvell Wyant</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nina M. Tichner</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-20-9298</i>		17. INFORMANT ADDRESS <i>Theresa G. Colbert 2352 Shade Tree La. Clearwater, Florida</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction secondary to atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>12-12-87</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/16/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D. C.</i>		
24. FUNERAL DIRECTOR NAME <i>George P. Kalas Funeral Home</i>		ADDRESS <i>6160 Oxon Hill Rd. Oxon Hill, Md.</i>		25. DATE REC'D. BY REGISTRAR <i>DEC 15 1987</i>		25. REGISTRAR'S SIGNATURE <i>Julia Benson-Rodriguez</i>			

03524 12171

204 COTTON FIBER

10000

10000



DEC 12 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene to provide burial, cremation, or removal.

IMPORTANT: If item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified of this.

Medical Examiner Notified/Approved

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		REG. NO. 36681					
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shelton NMN OWENS				2a. DATE OF DEATH MONTH DAY YEAR December 3, 1987		2b. HOUR 2:50 A			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL OF PR. GEO. CO				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher's Helper		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Cap. Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1142 Booker Dr. 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Shelton Owens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maple Carter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 244-26-0617		17. INFORMANT ADDRESS Jeanette R. Owens-Same as # 9 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C-M-F</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rita R. Shuh MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rita R. Shuh, M.D.				22e. ADDRESS 14333 Laurel Bowie Rd Suit-300 Laurel MD					
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G. MD. 20708			
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS				ADDRESS 4925 BURNBOUGHS AVE, N.C.		25a. DATE REC'D. BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE John Davidson	

BP

NY 100-101-568

Handwritten notes and stamps, including "RECEIVED" and "EXHIBIT" markings, are visible across the page. The text is mirrored and difficult to read due to the image quality.

077295 JAN - 68

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36682

1. DECEASED NAME (TYPE OR PRINT) Anne G. Padgett			2a. DATE OF DEATH MONTH DAY YEAR December 21, 1987			2b. HOUR 11 ⁰⁶ PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 16, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? Canada		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD			12b. KIND OF BUSINESS OR INDUSTRY P.G. Hospital		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Laurel						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14200 Laurel Park Dr 20707			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Madore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola McClusky							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Norma N. Marques		ADDRESS 12908 Old Chapel Pl. Bowie, Md. 20715					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse intravascular coagulopathy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cirrhosis of liver, Chronic renal insufficiency, Hepatic encephalopathy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from December 2, 1987, to December 21, 1987 that (I) (we) last saw the deceased alive on December 21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chih-Hung Chen				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED December 22, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chih-Hung Chen				22e. ADDRESS 6001 Landover Road Cheverly, M.D. 20785							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Dec 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Medical School		23d. LOCATION Washington, D.C.					
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services 225 Missouri Ave N.W. Wash D.C. 20011				25a. DATE REC'D BY REGISTRAR DEC 29 1987		25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or if the medical examiner must be notified, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

BP

UNIVERSITY MICROFILMS
SERIALS ACQUISITION
300 N ZEEB RD
ANN ARBOR MI 48106-1500

05552 3M-200

(11)

76919 DEC 31

87 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36683

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Mary Palmer			2a. DATE OF DEATH MONTH DAY YEAR 12 29 87		2b. HOUR 2 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 13 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH P.G.		MD.			
10. CITY OR TOWN OF DEATH LAUREL, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY private					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland P.G.		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 4500 Usange St. 20705	
14. FATHER'S NAME FIRST MIDDLE LAST Richard A. Bickerton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Schaefer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-36-3618		17. INFORMANT ADDRESS Paula Ann Noel 3382 Wye Mills S. 20707	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Bladder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Crohn's Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 11/0 , 19 83 , to 12/28 , 19 87 , that (I) (we) lost saw the deceased alive on 12/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Dennis Schumer		DEGREE MD		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis Schumer		22e. ADDRESS 14201 LAUREL PARK DR. #102 LAUREL, MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/88		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION Washington		COUNTY DC		STATE	
24. BURIAL DIRECTOR Borgwardt Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 31 1987		25b. REGISTRAR'S SIGNATURE John L. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 35584

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Marianna Antoinette PAULEY			7a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1987			7b. HOUR 10:45 P			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P. G. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Pr. George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown			13e. STREET ADDRESS / ZIP CODE 12012 Long Ridge Lane 20715			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Diane A. Shedd		ADDRESS 12012 Long Ridge Lane Bowie, Maryland 20715			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GANGRENE LARGE BOWEL									
19a. DATE OF OPERATION 12/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 12/21/87		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 87 , to 12-25 , 19 87 , that (I) (we) lost saw the deceased alive on 12-25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. JOSEPH MATHEN				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. JOSEPH MATHEN				22e. ADDRESS 6510 KENIL WORTH AVE RIVERDALE LG. MD 21153					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC 29, 1987		23c. NAME OF CEMETERY OR CREMATORY National Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of fact.

7001 1000

Mr. George A. Jones
1512 Long Ridge Road
Baltimore, Md. 21202
Source: Bureau of P. O. Co.
Baltimore, Md.
County: Baltimore

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Baltimore, Md.
County: Baltimore

075982 DEC 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 36685

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Gene Anthony Pelosi, Sr.			Dec. 19 87			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	Caucasian	Aug. 14, 1933	54 YRS.			Dec. 19, 1987	7:20A	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			U.S.A.			Prince George's MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Forestville			1920 County Rd., #203			Contractor		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS			13b. CITY OR TOWN		
Flooring			1900 County Rd., #203			20747		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Virginio			Dora			Yes		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
1953-1955			Joseph M. Pelosi			4421 Rena Rd., T-3 Forestville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Elkylism</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) Deputy			DATE SIGNED 12-18-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn Ct., Temple Hills, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation			12/20/87		Metropolitan Crematory		Alexandria Virginia	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George P. Kalas Funeral Home Oxon Hill, Md.			DEC 22 1987			<i>John P. ...</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 750.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

CHIEF MANAGER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36680

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST DORIS	MIDDLE PEOPLES	LAST PEOPLES	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 9 02 A.M.		
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR SEPT 20 1934		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) south carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE M.D..		13b. COUNTY P.G.		13c. CITY OR TOWN RIVERDALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JESSIE WILLIAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL DAMON				16. STREET ADDRESS / ZIP CODE 6403 GREENVALE PKWY 20737			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 248-50-9627		17. INFORMANT ADDRESS LEEVERN PEOPLES 6403 GREENVALE PKWY RIVERDALE M.D.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio Pulmonary Arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Chronic Renal Failure</i> (b) <i>Diabetes Mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (i) this hospital attended the deceased from <i>Oct 17</i> 19 <i>86</i> to <i>12-09</i> 19 <i>87</i> , that (ii) (we) lost <i>see the deceased alive on above</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <i>above</i> .											
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD MRCP				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KISHPAL SINGH		22e. ADDRESS 7525 GREENWAY CENTER Drive GREENBELT MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-15-87		23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MARYLAND					
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a. DATE REC'D. BY REGISTRAR DEC 17 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

10-27-10 10:15 AM

10



BP

DHMH - 16 60M 7/84
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and retain them for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		11-13-87 1-10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		BLACK		JAN 4 1958		29		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				PRINCE GEORGES		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		SOUTHERN MARYLAND HOSPITAL		NONE		NONE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
M.D.		P.G.		CLINTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9252 PISCATAWAYS RD. 20735	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
BENNIE		GERTRUDE		NO		217-68-8063		GERTRUDE PERRY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) HEPATIC COMA						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE OF CIRRHOSIS OF LIVER								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DAYS.	
DUE TO, OR AS A CONSEQUENCE OF (c) Gram Negative septicemia								MONTHS.	
								days.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
CHRONIC -RECURRENT PANCREATITIS, SECONDARY ANEMIA, CACHEXIA									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. DATE SIGNED			
		HOUR A.M. MONTH DAY YEAR				NOV. 13 '87			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		22b. SIGNATURE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE		PETER W. YIM M.D.			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13 1987, to Nov. 13 1987, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
		DEGREE		22e. ADDRESS		PETER W. YIM M.D.			
		M.D.		7900 OLD BRANCH AVE. SUITE 101					
		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		CLINTON, MARYLAND 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		11-19-87		RESURRECTION CEMETERY		CLINTON			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. COUNTY		25d. STATE	
ROLLINS FUNERAL HOME, INC.		JAN 12 1988		[Signature]		P.G.		MARYLAND	
4339 HUNT PLACE, N.E.									
WASHINGTON, D.C. 20019									

69-41 KRL-1-1337

WESTERN CO. 2012
4332 HUNT PLACE, N.E.
TOLLING FUNERAL HOME, INC.

JAN 12 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

075242 DEC 16 87

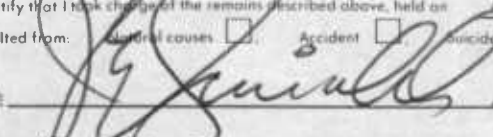
87 REG. NO. 36588

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MERCEDES N. PEZZINGA				12 10 87		5:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	WHITE	Oct. 29 1896		91			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Italy	Italy			Prince George		MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Ianham	Prince George General Hospital		Co-owner		Restaurant		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD		Somerset	Crisfield			414 Myrtle St. / 21817	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Alfredo Neri		Josephine Gazzanelli		No		218-34-4108	
17. INFORMANT		ADDRESS		17a. DATE OF DEATH		17b. TIME OF DEATH	
Anna Maria McCoy		16002 Alderwood Lane		Bowling, MD		20716	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>						20 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u>						10 years	
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 11/11/85 to 12/10/87, that (2) we last saw the deceased alive on 12/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) 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077853 JAN 15 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36539

1. DECEASED NAME (TYPE OR PRINT)			FIRST Victor			MIDDLE Norman			LAST Physioc			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 31 87				2b. HOUR M 10:25 A			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1950		6. AGE (IN YEARS) LAST BIRTHDAY 37 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 2 19 88				2d. HOUR A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD							
10. CITY OR TOWN OF DEATH Seat Pleasant				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Addison Rd & Eastern Avenue								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter				12b. KIND OF BUSINESS OR INDUSTRY Painting Co.			
13a. STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6603 Stockton Lane 20784									
14. FATHER'S NAME FIRST MIDDLE LAST Jean Physioc						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Rigor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Vietnam		17. INFORMANT ADDRESS Ruth E. Physioc, Same as Line #13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drug intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-31- 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Found in woods off				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Addison Rd. & Eastern Ave., Prince George's Seat Pleasant MD											
22a. I certify that I have charged the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) Chief				MEDICAL EXAMINER				DATE SIGNED 1/3/88							
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.				ADDRESS 111 Penn St. Balto.MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 01-05-88		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia									
24. FUNERAL HOME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ENCLINITE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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REF ID: A61760-2002

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UNCLASSIFIED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 0 5 9 0

1- STATE REGISTRAR		2- DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3- SEX		4- RACE		5- DATE OF BIRTH		6- AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7a- DATE KNOWN OF DEATH		8- MONTH DAY YEAR		9- HOUR	
		JOSEPH C. PICA				Male		Caucasian		Oct. 1, 1923		64 YRS.						12 8 19 87		10:57		M	
7a- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b- CITIZEN OF WHAT COUNTRY?		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9- BALTIMORE CITY OR COUNTY OF DEATH																	
Illinois		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's County																	
10- CITY OR TOWN OF DEATH		11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b- KIND OF BUSINESS OR INDUSTRY																	
Camp Springs		Malcolm Grow Medical Center		Retired Air Force		US Govt.																	
13a- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b- STATE		13c- COUNTY		13d- CITY OR TOWN		13e- INSIDE CITY LIMITS?		13f- STREET ADDRESS													
Maryland		P. G.				Camp Springs		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6709 Geneva Lane		20748											
14- FATHER'S NAME		15- MOTHER'S MAIDEN NAME																					
Andrew		Anfelina																					
16a- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/>)		16b- SOCIAL SECURITY NO.		17- INFORMANT		ADDRESS																	
Yes		1943-1974		340-18-4865		Virginia Pica		Same as 13 A-E															

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Thoracic trauma with complications			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
Hypertensive arteriosclerotic cardiovascular disease			
19a- DATE OF OPERATION		19b- CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a- EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b- TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		8:06xx 11-30- 1987	
21c- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d- INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	
Driver of auto/pick up truck collision.		21e- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		road	
21f- LOCATION		21g- CITY OR TOWN	
		Allentown Rd., Morningside, Prince George's, MD	

22a- I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)	
		Deputy Chief	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Ann M. Dixon, M.D.		12-9-87	
ADDRESS		MEDICAL EXAMINER	
111 Penn St., Balto., MD 21201			

23a- BURIAL, CREMATION, REMOVAL (SPECIFY)		23b- DATE		23c- NAME OF CEMETERY OR CREMATORY		23d- LOCATION	
Burial		12/11/87		Arlington National Cem.		Arlington Arlington VA.	
24- FUNERAL DIRECTOR NAME		25a- DATE REC'D BY REGISTRAR		25b- REGISTRAR'S SIGNATURE			
Lee Funeral Home, Inc.		DEC 16 1987					
6633 Old Alexander Ferry Rd. Clinton, Md 20735							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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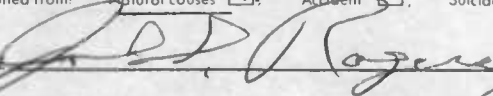

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 5A, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 000092

1- STATE REGISTRAR										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/11 19 87										21. HOUR M																															
DECEASED NAME (TYPE OR PRINT) Irene Craig Pilson										22. DATE PRONOUNCED DEAD 12/11 19 87										23. HOUR A M 9:45																															
3 SEX Female		4. RACE White		5. DATE OF BIRTH Sep. 20, 1894		6. AGE (IN YEARS) 93 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.									
10. CITY OR TOWN OF DEATH Hyattsville										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker										12b. KIND OF BUSINESS OR INDUSTRY Home																					
13a. STATE MD										13b. COUNTY Prince Georges										13c. CITY OR TOWN Hyattsville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 4922 La Salle Rd. 20782											
14. FATHER'S NAME FIRST John MIDDLE C. LAST Craig										15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Hall LAST Hall										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 577-22-3934										17. INFORMANT ADDRESS Elizabeth Pilson Imirie 3813 Williams La Chevy Chase, MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic brain syndrome.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF																										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18. None																																																			
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None																															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																																			
ACTUAL SIGNATURE 										TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 12/14/87																															
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD																																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 12/15/87										23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem										23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC																					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.										ADDRESS 5130 WI Ave. NW Wash., DC 20016										25a. DATE REC'D. BY REGISTRAR DEC 16 1987						25b. REGISTRAR'S SIGNATURE 																									

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Rock Creek Cem

12/17/07

Wash., D.C.

Joseph J. ...

2300 W Ave. ...

Wash., D.C.

DEC 16 1907

for ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death must be notified at once.

DHMH - 16 60M 7/84
(VIA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8730593
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CATHERINE V. PIPPERT				12 09 87		2 05PM M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female	White	Nov 10, 1919		68 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington DC	USA			PRINCE GEORGES COUNTY		MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER		Housewife		Own Home		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
Maryland		Pr George	Forestville	YES <input type="checkbox"/> NO <input type="checkbox"/>	2616 Boones Lane 20747		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Joseph W Smith		Helen Howard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		214-18-2896		Carl F. Pippert		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Comatose state</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Anoxia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC RENAL FAILURE, DIABETES MELITUS, PLURAL EFFUSION.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>87</u> , to <u>12-8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>El Bonoie</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>12-10-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
R.G. BHOTRAJ, M.D.		704 GORMAN AVE, LAUREL, MD 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-12-87		Cedar Hill Cemetery		Suitland PG Md	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert E Wilhelm Funeral Home		Suitland, Md		DEC 14 1987		<u>John A. ...</u>	

BP

0076035 DEC 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30594

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angelo M. Pometto			20. DATE OF DEATH MONTH DAY YEAR 12 - 18 - 1987		21. HOUR 10:45
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 31 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rome-Italy		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home		12a. USUAL OCCUPATION (TIME OF LIFE) Ret. Engineer	
13a. STATE --		13b. COUNTY --		13c. CITY OR TOWN Washington, DC	
14. FATHER'S NAME FIRST MIDDLE LAST Luigi Pometto		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 579-26-9630		17. INFORMANT ADDRESS College	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Others chronic DUE TO, OR AS A CONSEQUENCE OF (c) Chronic - Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 3, 1984 , to 12 , 19 87 , that (I) (we) lost saw the deceased alive on Oct. 30, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ciro A. Montanero MD		DEGREE MD		22c. DATE SIGNED 12.18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ciro A. Montanero MD		22e. ADDRESS 3308 Dodge PK Rd Landover			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION Brentwood		P.O. CITY P.O.		STATE Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., SIL. Spr. Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1987	
		25b. REGISTRAR'S SIGNATURE Julia D. ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

0-2-0000000000

19 - 18 - 1987 1985

Tomato M. No. 10

7 31 1898 21

Roma-Italy U. S. A. Prince George

Mitchellville Villa Roma Nursing Home Coal Mines

Green Island, Ontario

6 1/2 in
1 1/2 in

From 1915 to 1917
1915 1917
1915 1917

075890 DEC 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20595

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST <i>Bessie L. Smith Poole</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-7 19 87			2b. HOUR M		
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR 5-1-1922		6. AGE (IN YEARS) (LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-7 19 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.	
10. CITY OR TOWN OF DEATH <i>Camp Springs</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Andrews AT-43 Md. Col. & Row Md. Col.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>D.C.</i>		13b. COUNTY <i>N/A</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>19 15th Street, N.E.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Willie Robinson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Louise Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579-32-6552</i>		17. INFORMANT ADDRESS <i>Sheila Johnson 19 15th Street, N.E.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>cardiovascular disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Renal impairment, pulmonary</i>											
19a. DATE OF OPERATION <i>12-8-87</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>				DATE SIGNED <i>12-8-87</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>Dec 12, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematorium</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>John L. Stewart III</i>						25a. DATE REC'D. BY REGISTRAR <i>DEC 22 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John L. Stewart III</i>			
Stewart Funeral Home 4001 Benning Rd. NE											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

UNITED STATES

NOV 10 1903

James T. Smith

10000 012

James T. Smith
10000 012

10000 012

James T. Smith

James T. Smith

07.6234 DEC 28 1987

#16 Film G636 2/5/88 kam

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

87 REG. NO. 35698

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myrtle Black POWERS			2a. DATE OF DEATH MONTH DAY YEAR December 17 1987		2b. HOUR a 6:00 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1893		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS, LAST BIRTHDAY) YRS MONTHS DAYS 94		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5508 43rd Pl.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY P.C. County				
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Finis A. Black			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nan Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 111-20-1766		17. INFORMANT ADDRESS James J. Powers, Jr. Camp Hill, Pa. 17011		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, secondary to arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Unknown					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from December 22, 1971 , to December 18, 1987 , that (I) (we) lost saw the deceased alive on 10 September 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. Medical examiner notified						
22b. SIGNATURE <i>Carl J. Houmann</i> DEGREE				22c. DATE SIGNED 18 Dec. 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M. D.				22e. ADDRESS 4404 Queensbury Rd. Riverdale, MD 20737		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 21, '87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood, Pr. Geo. Md.		
23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Md. 20781		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE DEC 24 1987		

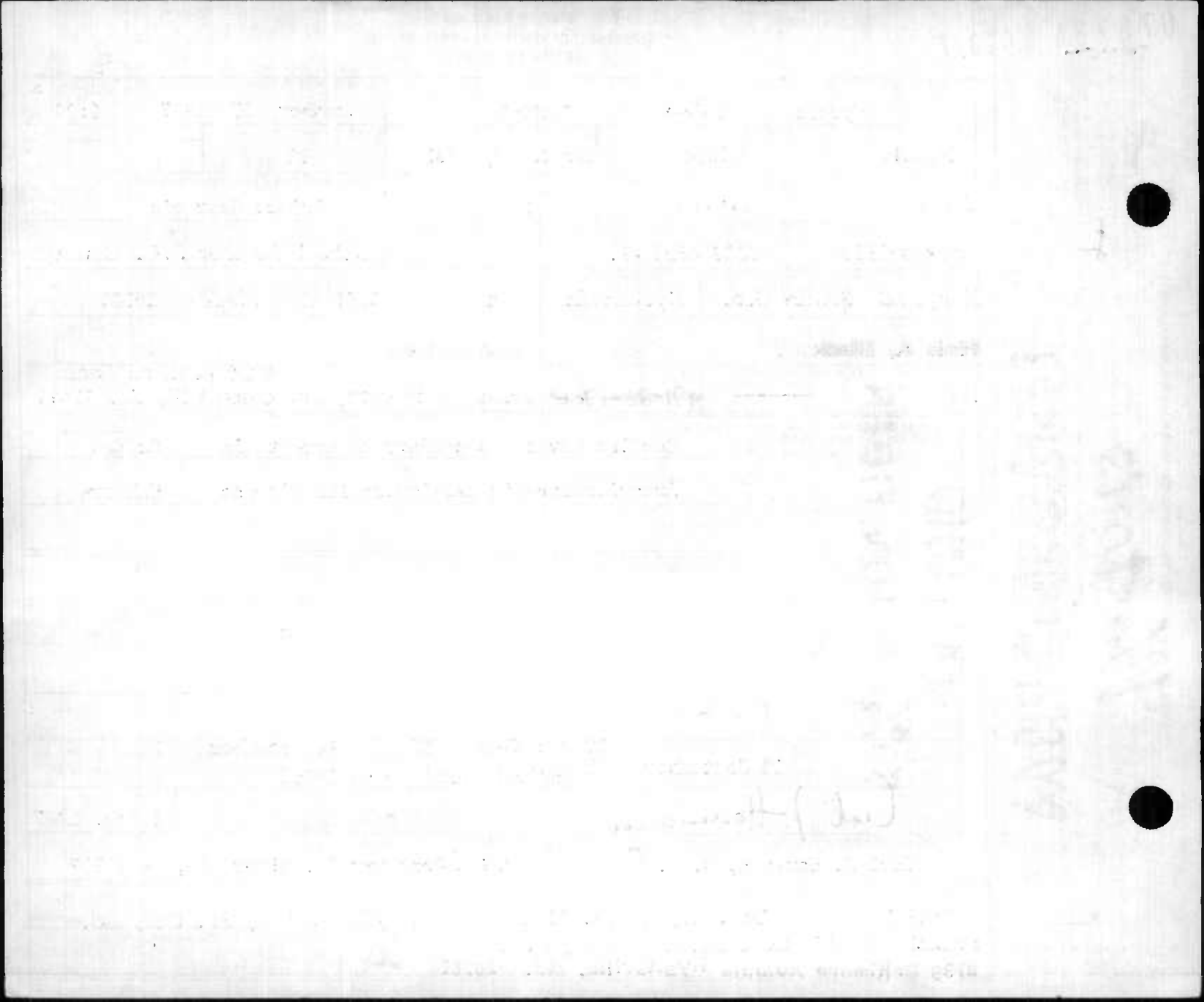
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30097

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
WILLIAM C. PRIDY			DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR			12 12 1987		
3. SEX			4. RACE			5. DATE OF BIRTH		
Male			Caucasian			May 14, 1966		
6. AGE (IN YEARS)			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		
21 YRS.			Maryland			U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
			Prince George's County MD			Cheverly		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Prince George's General Hospital			Student			College		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN		
Maryland			A.A. Co.			Severna Park		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Richard H. Priddy			Jacqueline L. Reichert			220745968		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION		
Richard H. Priddy (Same as Above # 13e)			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
			(b) DUE TO, OR AS A CONSEQUENCE OF			20. AUTOPSY?		
			(c) DUE TO, OR AS A CONSEQUENCE OF			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
			3:08 PM 12-12-87			Pedestrian struck by auto.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
			road			5400 blk. Greenbelt Rd., Berwyn Heights, MD		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			12-15-1987			Hillcrest Cem.		
23d. LOCATION (CITY OR TOWN)			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Cumberland, MD			DEC 17 1987			Julia Davidson-Budack		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
ROBERT S. BARRANCO			DEC 17 1987			Julia Davidson-Budack		
SEVERNA PARK, MD. 21146								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH PAGES 1, 2, AND 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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DIVID

RECEIVED

WATKINS



[Handwritten signature]

ROBERT S. BARRAGE

SEVENNA LANE MD 21144

3288

071030

February 24, 1971

From

To

Station

February 24, 1971

File

U.S.A.

Original issued during 1968

12-24-71

12-24-71

Reference

Reference

Notes

Notes

Notes

Notes

12-24-71

Original issued during 1968

12

12

12

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 35599

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS Jane QUILLEN		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 20, 1987		2b. HOUR 9:30 A.M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 3/2/01		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY P.C.		13c. CITY OR TOWN BLADENSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME John		15 MOTHER'S MAIDEN NAME Effie Covil		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 577-52-3987	
17 INFORMANT Marion T. Quillen (Son)		ADDRESS 3002 Laurel Avenue		Cheverly, Md.		20785	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Stroke - Coma</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19/87</u> to <u>12/20/87</u> that (I) (we) last saw the deceased alive on <u>12/19/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) <u>examine the body after death.</u>							
22b. SIGNATURE <u>Abraham Dabela</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA		22e. ADDRESS 4404 Queensbury Rd. Riverdale, Md. 20737					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/23/87		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>	

100522 108050



1- FOR STATE REGISTRAR 1-26-88 I.J.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36700

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
Louie		Frank	Ramsey Sr	12-30-87		12		30	87	PM
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR
Male	Black	Aug. 8, 1911	76			12-30-87		12	30	PM
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		PG			
Alabama	USA				PG					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Capitol Heights	133 Maryland Park Drive		Retired		Gov.					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Maryland	PG	Capt. Hgts.		133 Maryland Park Drive						
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Saul Ramsey					Mary Bell Ruffin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no			418 07 3066A		Thelma Ramsey-wife-133 Maryland Park					

18 CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Asterosporiosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>	TITLE (SPECIFY) <u>Deputy</u> M.D. MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u>	DATE SIGNED <u>12-31-87</u>
ADDRESS <u>5009 Rayburn Ct, Temple Hills, MD</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY
Burial	Jan. 5, 1988	Lincoln Memorial Park	Suitland, Maryland
24. FUNERAL DIRECTOR NAME		DATE REC'D. BY REGISTRAR	REGISTRAR'S SIGNATURE
Stewart Funeral Home		JAN. 6 1988	<u>Julia Davidson</u>
ADDRESS <u>4001 Benning Road</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36701

2a. DECEASED NAME (TYPE OR PRINT) Walter V. Rau			2b. DATE OF DEATH MONTH DAY YEAR December 24, 1987			2c. HOUR 9:03A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Nat'l Educ. Ass'n	
13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Glenn Dale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter S. Rau			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie VanHorn			13e. STREET ADDRESS / ZIP CODE 11005 Prospect Hill Road 20769			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Ellen R. Rau		ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock + CHF</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7	
								7	
								1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>hypertension; chronic xis; obesity</u>									
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-16-87</u> 19 <u>87</u> , to <u>12-24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-24-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. [Signature]				22e. ADDRESS 9376 [Signature] MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec. 24 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Rd Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

FOOTED DEC 31 1961

Handwritten notes and stamps, including "USA" and "1961".

DEC 30 1961

077245 JAN

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove substitution papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78


STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 REG. NO. 36702							
1. DECEASED NAME (THIS COUNTY) FIRST MIDDLE LAST DOROTHY B. REUTER				2a. DATE OF DEATH MONTH DAY YEAR 12 31 87		2b. HOUR 510 A M			
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 3 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD			
10 CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN Virginia N/A Arlington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 4140 N. River Street 22207			
14 FATHER'S NAME FIRST MIDDLE LAST Jeremiah S. Sullivan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Beaton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 018-32-6288		17 INFORMANT (Daughter) Jacqueline M. VanBesien		ADDRESS 4140 N. River St. Arlington, Va.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROGRESSIVE CEREBRAL THROMBOSIS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 48 HRS YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> , 19 <u>86</u> , to <u>DECEMBER 31</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/30/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Marta Anne Schneider MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTA ANNE SCHNEIDER MD				22e. ADDRESS 5401 MACARTHUR BLVD N.W. WASH. D.C. 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/11/88		23c. NAME OF CEMETERY OR CREMATORY Newton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Newton Middlesex Mass.			
24 FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR JAN 5 1988					

JAN 5 1988

076577

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36703

1. DECEASED NAME (TYPE OR PRINT) DAVID E. REYNOLDS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 22 19 87			2b. HOUR 6:51 PM		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 7/2/68	6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 22 19 87		
BIRTHPLACE (STATE OR FOREIGN COUNTRY) OMAHA, NEB.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inventory CLK, Pvt		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY P.G.	13c. CITY OR TOWN FT. WASH.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 6319 BENTHAM CT.			
14. FATHER'S NAME FIRST MIDDLE LAST William E. POOLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DEBRA J. REYNOLDS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578 922401		17. INFORMANT Mother 6319 Bentham St. Ft. Wash MD DEBRA REYNOLDS-POOLE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 PM 12-22-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building		21f. LOCATION CITY OR TOWN COUNTY STATE 6506 Calmos St., Capitol Heights, Prince MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> George's								
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy Chief			DATE SIGNED 12-23-87		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL REMOVAL			23b. DATE 12/26/87		23c. NAME OF CEMETERY OR CREMATORY MYER'S F.H.		23d. LOCATION (CITY OR TOWN) COUNTY STATE OMAHA, NEBRASKA	
24. FUNERAL DIRECTOR NAME ADDRESS ALEXANDER S. POPE 2617 PA AVE WASH DC			25a. DATE REC'D. BY REGISTRAR DEC 29 1987			25b. REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-7. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

075949 DEC 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36704

1. DECEASED NAME (TYPE OR PRINT) ELSTE MAGLENE RICHARDS		2a. DATE OF DEATH MONTH DAY YEAR 12-18-87		2b. HOUR M 1:15 PM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 03-06-13		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County		10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STREET ADDRESS 8600 Mike Shapiro Dr/2073	
13b. STATE Maryland		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Boswell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Burch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None	
16b. SOCIAL SECURITY NO. 213-44-6855		17. INFORMANT ADDRESS 16101 Tanyard Rd. Upper Marlboro, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) IRREVERSIBLE SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DIABETES MELLITUS, HYPOTHYROIDISM, RHEUMATOID ARTHRITIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 12/13/87 , 19____, to 12/18/87 , 19____, that (I) (we) lost the deceased alive on 12/17/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE Smishra for G.S. RATH	
22c. DATE SIGNED 12/18/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAWJEEB K. MISHRA		22e. ADDRESS Charles Ref Center Waldorf, Md, 20601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Pr. Geo., Md.		24. FUNERAL DIRECTOR NAME Hunt Funeral Home		25. DATE REC'D BY REGISTRAR DEC 22 1987	
25a. REGISTRAR'S SIGNATURE Julia Jordon-Randall		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S. DEPARTMENT OF THE INTERIOR

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 4 1988	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (CITY AND TOWN) Landover, Maryland
24. FUNERAL DIRECTOR NAME Stewart	25a. DATE REC'D. BY REGISTRAR JAN 6 1988		25b. REGISTRAR'S SIGNATURE John Davidson-Randall

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 11:16 AM 12-29-1987	21b. TIME OF INJURY HOURS MONTH DAY YEAR 11:16 12-29-1987	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by auto.
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5300 blk. Sheriff Rd., Fairmont Heights, MD Prince George's
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE Mario F. Golle, Jr., M.D.		TITLE (SPECIFY) MD Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.		DATE SIGNED 12-30-87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 30. 5 7 0 5							
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR					
DECEASED NAME (PRINT) FIRST MIDDLE LAST TIMOTHY RICHARDSON										MONTH DAY YEAR 12 29 87		M 11:59 PM					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Apr. 3, 1971		6. AGE (IN YEARS) LAST BIRTHDAY 16		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 29 87		2d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Washington, D.C.										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 815 Eastern Avenue, N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Shandy Richardson										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Ann Queen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 579 94 0579				17. INFORMANT ADDRESS 815 Eastern Ave, N.E. Shandy Richardson-father-									

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6700

1 DECEASED NAME (TYPE OR PRINT)		FIRST <i>Frim</i>		MIDDLE <i>Mitchell</i>		LAST <i>Riddick</i>		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b HOUR	
3 SEX <i>Male</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>4 15 42</i>		6 AGE (IN YEARS) (LAST BIRTHDAY) <i>45</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c DATE PRONOUNCED DEAD <i>12-16 1987 10:55 AM</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
10 CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George General</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Private</i>					
13a. STATE <i>MD.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Seat Pleasant</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>6715 Hastings Drive</i>		<i>20743</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Willie Riddick</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katie Speed</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>N/A</i>		17 INFORMANT <i>Corrine Riddick</i>		ADDRESS <i>6715 Hastings Drive</i>		<i>Seat Pleasant MD.</i>			
18 CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Myocardial infarction disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER				DATE SIGNED <i>12-</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez MD</i>		ADDRESS <i>5009 Rayburn Ct. Cp Spr. Md 20748</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Dec. 21, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Mem. Park</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, MD.</i>			
24 FUNERAL DIRECTOR NAME <i>John T. Stewart</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 22 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							
Stewart Funeral Home 4001 Benning Rd. NE											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

012881 088270

Wm. Clark
1000
1000

20% COTTON FIBER

1000

WATKINS



1000

077464 JAN - 7 1988

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 35707

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE OF DEATH		2d. DATE OF DEATH		2e. DATE OF DEATH		2f. DATE OF DEATH		2g. DATE OF DEATH		2h. DATE OF DEATH		2i. DATE OF DEATH		2j. DATE OF DEATH		2k. DATE OF DEATH		2l. DATE OF DEATH		2m. DATE OF DEATH		2n. DATE OF DEATH		2o. DATE OF DEATH		2p. DATE OF DEATH		2q. DATE OF DEATH		2r. DATE OF DEATH		2s. DATE OF DEATH		2t. DATE OF DEATH		2u. DATE OF DEATH		2v. DATE OF DEATH		2w. DATE OF DEATH		2x. DATE OF DEATH		2y. DATE OF DEATH		2z. DATE OF DEATH																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK)		13. KIND OF BUSINESS OR INDUSTRY		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE		21j. ZIP CODE		21k. ZIP CODE		21l. ZIP CODE		21m. ZIP CODE		21n. ZIP CODE		21o. ZIP CODE		21p. ZIP CODE		21q. ZIP CODE		21r. ZIP CODE		21s. ZIP CODE		21t. ZIP CODE		21u. ZIP CODE		21v. ZIP CODE		21w. ZIP CODE		21x. ZIP CODE		21y. ZIP CODE		21z. ZIP CODE		21aa. ZIP CODE		21ab. ZIP CODE		21ac. ZIP CODE		21ad. ZIP CODE		21ae. ZIP CODE		21af. ZIP CODE		21ag. ZIP CODE		21ah. ZIP CODE		21ai. ZIP CODE		21aj. ZIP CODE		21ak. ZIP CODE		21al. ZIP CODE		21am. ZIP CODE		21an. ZIP CODE		21ao. ZIP CODE		21ap. ZIP CODE		21aq. ZIP CODE		21ar. ZIP CODE		21as. ZIP CODE		21at. ZIP CODE		21au. ZIP CODE		21av. ZIP CODE		21aw. ZIP CODE		21ax. ZIP CODE		21ay. ZIP CODE		21az. ZIP CODE		21ba. ZIP CODE		21bb. ZIP CODE		21bc. ZIP CODE		21bd. ZIP CODE		21be. ZIP CODE		21bf. ZIP CODE		21bg. ZIP CODE		21bh. ZIP CODE		21bi. ZIP CODE		21bj. ZIP CODE		21bk. ZIP CODE		21bl. ZIP CODE		21bm. ZIP CODE		21bn. ZIP CODE		21bo. ZIP CODE		21bp. ZIP CODE		21bq. ZIP CODE		21br. ZIP CODE		21bs. ZIP CODE		21bt. ZIP CODE		21bu. ZIP CODE		21bv. ZIP CODE		21bw. ZIP CODE		21bx. ZIP CODE		21by. ZIP CODE		21bz. ZIP CODE		21ca. ZIP CODE		21cb. ZIP CODE		21cc. ZIP CODE		21cd. ZIP CODE		21ce. ZIP CODE		21cf. ZIP CODE		21cg. ZIP CODE		21ch. ZIP CODE		21ci. ZIP CODE		21cj. ZIP CODE		21ck. ZIP CODE		21cl. ZIP CODE		21cm. ZIP CODE		21cn. ZIP CODE		21co. ZIP CODE		21cp. ZIP CODE		21cq. ZIP CODE		21cr. ZIP CODE		21cs. ZIP CODE		21ct. ZIP CODE		21cu. ZIP CODE		21cv. ZIP CODE		21cw. ZIP CODE		21cx. ZIP CODE		21cy. ZIP CODE		21cz. ZIP CODE		21da. ZIP CODE		21db. ZIP CODE		21dc. ZIP CODE		21dd. ZIP CODE		21de. ZIP CODE		21df. ZIP CODE		21dg. ZIP CODE		21dh. ZIP CODE		21di. ZIP CODE		21dj. ZIP CODE		21dk. ZIP CODE		21dl. ZIP CODE		21dm. ZIP CODE		21dn. ZIP CODE		21do. ZIP CODE		21dp. ZIP CODE		21dq. ZIP CODE		21dr. ZIP CODE		21ds. ZIP CODE		21dt. ZIP CODE		21du. ZIP CODE		21dv. ZIP CODE		21dw. ZIP CODE		21dx. ZIP CODE		21dy. ZIP CODE		21dz. ZIP CODE		21ea. ZIP CODE		21eb. ZIP CODE		21ec. ZIP CODE		21ed. ZIP CODE		21ee. ZIP CODE		21ef. ZIP CODE		21eg. ZIP CODE		21eh. ZIP CODE		21ei. ZIP CODE		21ej. ZIP CODE		21ek. ZIP CODE		21el. ZIP CODE		21em. ZIP CODE		21en. ZIP CODE		21eo. ZIP CODE		21ep. ZIP CODE		21eq. ZIP CODE		21er. ZIP CODE		21es. ZIP CODE		21et. ZIP CODE		21eu. ZIP CODE		21ev. ZIP CODE		21ew. ZIP CODE		21ex. ZIP CODE		21ey. ZIP CODE		21ez. ZIP CODE		21fa. ZIP CODE		21fb. ZIP CODE		21fc. ZIP CODE		21fd. ZIP CODE		21fe. ZIP CODE		21ff. ZIP CODE		21fg. ZIP CODE		21fh. ZIP CODE		21fi. ZIP CODE		21fj. ZIP CODE		21fk. ZIP CODE		21fl. ZIP CODE		21fm. ZIP CODE		21fn. ZIP CODE		21fo. ZIP CODE		21fp. ZIP CODE		21fq. ZIP CODE		21fr. ZIP CODE		21fs. ZIP CODE		21ft. ZIP CODE		21fu. ZIP CODE		21fv. ZIP CODE		21fw. ZIP CODE		21fx. ZIP CODE		21fy. ZIP CODE		21fz. ZIP CODE		21ga. ZIP CODE		21gb. ZIP CODE		21gc. ZIP CODE		21gd. ZIP CODE		21ge. ZIP CODE		21gf. ZIP CODE		21gg. ZIP CODE		21gh. ZIP CODE		21gi. ZIP CODE		21gj. ZIP CODE		21gk. ZIP CODE		21gl. ZIP CODE		21gm. ZIP CODE		21gn. ZIP CODE		21go. ZIP CODE		21gp. ZIP CODE		21gq. ZIP CODE		21gr. ZIP CODE		21gs. ZIP CODE		21gt. ZIP CODE		21gu. ZIP CODE		21gv. ZIP CODE		21gw. ZIP CODE		21gx. ZIP CODE		21gy. ZIP CODE		21gz. ZIP CODE		21ha. ZIP CODE		21hb. ZIP CODE		21hc. ZIP CODE		21hd. ZIP CODE		21he. ZIP CODE		21hf. ZIP CODE		21hg. ZIP CODE		21hh. ZIP CODE		21hi. ZIP CODE		21hj. ZIP CODE		21hk. ZIP CODE		21hl. ZIP CODE		21hm. ZIP CODE		21hn. ZIP CODE		21ho. ZIP CODE		21hp. ZIP CODE		21hq. ZIP CODE		21hr. ZIP CODE		21hs. ZIP CODE		21ht. ZIP CODE		21hu. ZIP CODE		21hv. ZIP CODE		21hw. ZIP CODE		21hx. ZIP CODE		21hy. ZIP CODE		21hz. ZIP CODE		21ia. ZIP CODE		21ib. ZIP CODE		21ic. ZIP CODE		21id. ZIP CODE		21ie. ZIP CODE		21if. ZIP CODE		21ig. ZIP CODE		21ih. ZIP CODE		21ii. ZIP CODE		21ij. ZIP CODE		21ik. ZIP CODE		21il. ZIP CODE		21im. ZIP CODE		21in. ZIP CODE		21io. ZIP CODE		21ip. ZIP CODE		21iq. ZIP CODE		21ir. ZIP CODE		21is. ZIP CODE		21it. ZIP CODE		21iu. ZIP CODE		21iv. ZIP CODE		21iw. ZIP CODE		21ix. ZIP CODE		21iy. ZIP CODE		21iz. ZIP CODE		21ja. ZIP CODE		21jb. ZIP CODE		21jc. ZIP CODE		21jd. ZIP CODE		21je. ZIP CODE		21jf. ZIP CODE		21jg. ZIP CODE		21jh. ZIP CODE		21ji. ZIP CODE		21jj. ZIP CODE		21jk. ZIP CODE		21jl. ZIP CODE		21jm. ZIP CODE		21jn. ZIP CODE		21jo. ZIP CODE		21jp. ZIP CODE		21jq. ZIP CODE		21jr. ZIP CODE		21js. ZIP CODE		21jt. ZIP CODE		21ju. ZIP CODE		21jv. ZIP CODE		21jw. ZIP CODE		21jx. ZIP CODE		21jy. ZIP CODE		21jz. ZIP CODE		21ka. ZIP CODE		21kb. ZIP CODE		21kc. ZIP CODE		21kd. ZIP CODE		21ke. ZIP CODE		21kf. ZIP CODE		21kg. ZIP CODE		21kh. ZIP CODE		21ki. ZIP CODE		21kj. ZIP CODE		21kl. ZIP CODE		21km. ZIP CODE		21kn. ZIP CODE		21ko. ZIP CODE		21kp. ZIP CODE		21kq. ZIP CODE		21kr. ZIP CODE		21ks. ZIP CODE		21kt. ZIP CODE		21ku. ZIP CODE		21kv. ZIP CODE		21kw. ZIP CODE		21kx. ZIP CODE		21ky. ZIP CODE		21kz. ZIP CODE		21la. ZIP CODE		21lb. ZIP CODE		21lc. ZIP CODE		21ld. ZIP CODE		21le. ZIP CODE		21lf. ZIP CODE		21lg. ZIP CODE		21lh. ZIP CODE		21li. ZIP CODE		21lj. ZIP CODE		21lk. ZIP CODE		21ll. ZIP CODE		21lm. ZIP CODE		21ln. ZIP CODE		21lo. ZIP CODE		21lp. ZIP CODE		21lq. ZIP CODE		21lr. ZIP CODE		21ls. ZIP CODE		21lt. ZIP CODE		21lu. ZIP CODE		21lv. ZIP CODE		21lw. ZIP CODE		21lx. ZIP CODE		21ly. ZIP CODE		21lz. ZIP CODE		21ma. ZIP CODE		21mb. ZIP CODE		21mc. ZIP CODE		21md. ZIP CODE		21me. ZIP CODE		21mf. ZIP CODE		21mg. ZIP CODE		21mh. ZIP CODE		21mi. ZIP CODE		21mj. ZIP CODE		21mk. ZIP CODE		21ml. ZIP CODE		21mm. ZIP CODE		21mn. ZIP CODE		21mo. ZIP CODE		21mp. ZIP CODE		21mq. ZIP CODE		21mr. ZIP CODE		21ms. ZIP CODE		21mt. ZIP CODE		21mu. ZIP CODE		21mv. ZIP CODE		21mw. ZIP CODE		21mx. ZIP CODE		21my. ZIP CODE		21mz. ZIP CODE		21na. ZIP CODE		21nb. ZIP CODE		21nc. ZIP CODE		21nd. ZIP CODE		21ne. ZIP CODE		21nf. ZIP CODE		21ng. ZIP CODE		21nh. ZIP CODE		21ni. ZIP CODE		21nj. ZIP CODE		21nk. ZIP CODE		21nl. ZIP CODE		21nm. ZIP CODE		21nn. ZIP CODE		21no. ZIP CODE		21np. ZIP CODE		21nq. ZIP CODE		21nr. ZIP CODE		21ns. ZIP CODE		21nt. ZIP CODE		21nu. ZIP CODE		21nv. ZIP CODE		21nw. ZIP CODE		21nx. ZIP CODE		21ny. ZIP CODE		21nz. ZIP CODE		21oa. ZIP CODE		21ob. ZIP CODE		21oc. ZIP CODE		21od. ZIP CODE		21oe. ZIP CODE		21of. ZIP CODE		21og. ZIP CODE		21oh. ZIP CODE		21oi. ZIP CODE		21oj. ZIP CODE		21ok. ZIP CODE		21ol. ZIP CODE		21om. ZIP CODE		21on. ZIP CODE		21oo. ZIP CODE		21op. ZIP CODE		21oq. ZIP CODE		21or. ZIP CODE		21os. ZIP CODE		21ot. ZIP CODE		21ou. ZIP CODE		21ov. ZIP CODE		21ow. ZIP CODE		21ox. ZIP CODE		21oy. ZIP CODE		21oz. ZIP CODE		21pa. ZIP CODE		21pb. ZIP CODE		21pc. ZIP CODE		21pd. ZIP CODE		21pe. ZIP CODE		21pf. ZIP CODE		21pg. ZIP CODE		21ph. ZIP CODE		21pi. ZIP CODE		21pj. ZIP CODE		21pk. ZIP CODE		21pl. ZIP CODE		21pm. ZIP CODE		21pn. ZIP CODE		21po. ZIP CODE		21pp. ZIP CODE		21pq. ZIP CODE		21pr. ZIP CODE		21ps. ZIP CODE		21pt. ZIP CODE		21pu. ZIP CODE		21pv. ZIP CODE		21pw. ZIP CODE		21px. ZIP CODE		21py. ZIP CODE		21pz. ZIP CODE		21qa. ZIP CODE		21qb. ZIP CODE		21qc. ZIP CODE		21qd. ZIP CODE		21qe. ZIP CODE		21qf. ZIP CODE		21qg. ZIP CODE		21qh. ZIP CODE		21qi. ZIP CODE		21qj. ZIP CODE		21qk. ZIP CODE		21ql. ZIP CODE		21qm. ZIP CODE		21qn. ZIP CODE		21qo. ZIP CODE		21qp. ZIP CODE		21qq. ZIP CODE		21qr. ZIP CODE		21qs. ZIP CODE		21qt. ZIP CODE		21qu. ZIP CODE		21qv. ZIP CODE		21qw. ZIP CODE		21qx. ZIP CODE		21qy. ZIP CODE		21qz. ZIP CODE		21ra. ZIP CODE		21rb. ZIP CODE		21rc. ZIP CODE		21rd. ZIP CODE		21re. ZIP CODE		21rf. ZIP CODE		21rg. ZIP CODE		21rh. ZIP CODE		21ri. ZIP CODE		21rj. ZIP CODE		21rk. ZIP CODE		21rl. ZIP CODE		21rm. ZIP CODE		21rn. ZIP CODE		21ro. ZIP CODE		21rp. ZIP CODE		21rq. ZIP CODE		21rr. ZIP CODE		21rs. ZIP CODE		21rt. ZIP CODE		21ru. ZIP CODE		21rv. ZIP CODE		21rw. ZIP CODE		21rx. ZIP CODE		21ry. ZIP CODE		21rz. ZIP CODE		21sa. ZIP CODE		21sb. ZIP CODE		21sc. ZIP CODE		21sd. ZIP CODE		21se. ZIP CODE		21sf. ZIP CODE		21sg. ZIP CODE		21sh. ZIP CODE		21si. ZIP CODE		21sj. ZIP CODE		21sk. ZIP CODE		21sl. ZIP CODE		21sm. ZIP CODE		21sn. ZIP CODE		21so. ZIP CODE		21sp. ZIP CODE		21sq. ZIP CODE		21sr. ZIP CODE		21ss. ZIP CODE		21st. ZIP CODE		21su. ZIP CODE		21sv. ZIP CODE		21sw. ZIP CODE		21sx. ZIP CODE		21sy. ZIP CODE		21sz. ZIP CODE		21ta. ZIP CODE		21tb. ZIP CODE		21tc. ZIP CODE		21td. ZIP CODE		21te. ZIP CODE		21tf. ZIP CODE		21tg. ZIP CODE		21th. ZIP CODE		21ti. ZIP CODE		21tj. ZIP CODE		21tk. ZIP CODE		21tl. ZIP CODE		21tm. ZIP CODE		21tn. ZIP CODE		21to. ZIP CODE		21tp. ZIP CODE		21tq. ZIP CODE		21tr. ZIP CODE		21ts. ZIP CODE		21tt. ZIP CODE		21tu. ZIP CODE		21tv. ZIP CODE		21tw. ZIP CODE		21tx. ZIP CODE		21ty. ZIP CODE		21tz. ZIP CODE		21ua. ZIP CODE		21ub. ZIP CODE		21uc. ZIP CODE		21ud. ZIP CODE		21ue. ZIP CODE		21uf. ZIP CODE		21ug. ZIP CODE		21uh. ZIP CODE		21ui. ZIP CODE		21uj. ZIP CODE		21uk. ZIP CODE		21ul. ZIP CODE		21um. ZIP CODE		21un. ZIP CODE		21uo. ZIP CODE		21up. ZIP CODE		21uq. ZIP CODE		21ur. ZIP CODE		21us. ZIP CODE		21ut. ZIP CODE		21uu. ZIP CODE		21uv. ZIP CODE		21uw. ZIP CODE		21ux. ZIP CODE		21uy. ZIP CODE		21uz. ZIP CODE		21va. ZIP CODE		21vb. ZIP CODE		21vc. ZIP CODE		21vd. ZIP CODE		21ve. ZIP CODE		21vf. ZIP CODE		21vg. ZIP CODE		21vh. ZIP CODE		21vi. ZIP CODE		21vj. ZIP CODE		21vk. ZIP CODE		21vl. ZIP CODE		21vm. ZIP CODE		21vn. ZIP CODE		21vo. ZIP CODE		21vp. ZIP CODE		21vq. ZIP CODE		21vr. ZIP CODE		21vs. ZIP CODE		21vt. ZIP CODE		21vu. ZIP CODE		21vv. ZIP CODE		21vw. ZIP CODE		21vx. ZIP CODE		21vy. ZIP CODE		21vz. ZIP CODE		21wa. ZIP CODE		21wb. ZIP CODE		21wc. ZIP CODE		21wd. ZIP CODE		21we. ZIP CODE		21wf. ZIP CODE		21wg. ZIP CODE		21wh. ZIP CODE		21wi. ZIP CODE		21wj. ZIP CODE		21wk. ZIP CODE		21wl. ZIP CODE		21wm. ZIP CODE		21wn. ZIP CODE		21wo. ZIP CODE		21wp. ZIP CODE		21wq. ZIP CODE		21wr. ZIP CODE		21ws. ZIP CODE		21wt. ZIP CODE		21wu. ZIP CODE		21wv. ZIP CODE		21ww. ZIP CODE		21wx. ZIP CODE		21wy. ZIP CODE		21wz. ZIP CODE		21xa. ZIP CODE		21xb. ZIP CODE		21xc. ZIP CODE		21xd. ZIP CODE		21xe. ZIP CODE		21xf. ZIP CODE		21xg. ZIP CODE		21xh. ZIP CODE		21xi. ZIP CODE		21xj. ZIP CODE		21xk. ZIP CODE		21xl. ZIP CODE		21xm. ZIP CODE		21xn. ZIP CODE		21xo. ZIP CODE		21xp. ZIP CODE		21xq. ZIP CODE		21xr. ZIP CODE		21xs. ZIP CODE		21xt. ZIP CODE		21xu. ZIP CODE		21xv. ZIP CODE		21xw. ZIP CODE		21xx. ZIP CODE		21xy. ZIP CODE		21xz. ZIP CODE		21ya. ZIP CODE		21yb. ZIP CODE		21yc. ZIP CODE		21yd. ZIP CODE		21ye. ZIP CODE		21yf. ZIP CODE		21yg. ZIP CODE		21yh. ZIP CODE		21yi. ZIP CODE		21yj. ZIP CODE		21yk. ZIP CODE		21yl. ZIP CODE		21ym. ZIP CODE		21yn. ZIP CODE		21yo. ZIP CODE		21yp. ZIP CODE		21yq. ZIP CODE		21yr. ZIP CODE		21ys. ZIP CODE		21yt. ZIP CODE		21yu. ZIP CODE		21yv. ZIP CODE		21yw. ZIP CODE		21yx. ZIP CODE		21yy. ZIP CODE		21yz. ZIP CODE		21za. ZIP CODE		21zb. ZIP CODE		21zc. ZIP CODE		21zd. ZIP CODE		21ze. ZIP CODE		21zf. ZIP CODE		21zg. ZIP CODE		21zh. ZIP CODE		21zi. ZIP CODE		21zj. ZIP CODE		21zk. ZIP CODE		21zl. ZIP CODE		21zm. ZIP CODE		21zn. ZIP CODE		21zo. ZIP CODE		21zp. ZIP CODE		21zq. ZIP CODE		21zr. ZIP CODE		21zs. ZIP CODE		21zt. ZIP CODE		21zu. ZIP CODE		21zv. ZIP CODE		21zw. ZIP CODE		21zx. ZIP CODE		21zy. ZIP CODE		21zz. ZIP CODE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Asphyxiation</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>Carbon Monoxide</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is:			
<u>None</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	
<u>None</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	<u>12:25 PM</u>	<u>In car in garage</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION	
	<u>Home</u>	<u>Narrows Lane Bowie Prince Georges Md</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide			

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076285 DEC 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 35708

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE Ruth ROBINSON		2a. DATE OF DEATH MONTH DAY YEAR 12 20 87		2b. HOUR 5 45 PM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR December 9, 1923	
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? United States	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
12b. KIND OF BUSINESS OR INDUSTRY Private		13a. STREET ADDRESS / ZIP CODE 7222 Landover Road #A 20785			
13b. COUNTY Prince George's Landover		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David Peugh Bowman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Seals			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 248-18-7570		17. INFORMANT ADDRESS 7222 Landover Rd Mary M. Brach/Daughter/Landover, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration Metabolic Acidosis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/P CVA DM HTN</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>87</u> , to <u>12/20</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>12/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Daniel OBLITAC</u>		DEGREE <u>PGGH</u>		22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL OBLITAC		22e. ADDRESS PGGH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1987 December 24		23c. NAME OF CEMETERY OR CREMATORY North View Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Florence South Carolina		24. FUNERAL DIRECTOR NAME ADDRESS Ideal Funeral Parlor, 1005 East Cheves Street, Florence, South Carolina			
25. DATE REC'D BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36709

DECEASED NAME (TYPE OR PRINT) CHARLIE LEE ROBINSON			7a. DATE OF DEATH MONTH DAY YEAR 12 3 87		7b. HOUR 3 22 AM
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 22 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUTTER	12b. KIND OF BUSINESS OR INDUSTRY ROANOKE ELEC. STEEL	
13a. STATE VA.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SHAWSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 112 24162	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ROBINSON	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA CALLAWAY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 719-14-0622		17. INFORMANT DAVID ROBINSON FT. WASHINGTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrest following pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction, peripheral vascular disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 12/21/87 to 12/23/87, that (I) (we) lost saw the deceased alive on 12/21/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. A. L.		DEGREE MD		22c. DATE SIGNED 12-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASHUTOSHAN J ANSARI		22e. ADDRESS 8926 WOODLAND RD #101 CLINTON MD. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-6-87	23c. NAME OF CEMETERY OR CREMATORY Piedmont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE SHAWSVILLE MONTG. VA.	
24. FUNERAL DIRECTOR NAME Grant E. Bryant		ADDRESS P.O. Box 8 ELLISTON, VA		25a. DATE REC'D. BY REGISTRAR DEC 24 1987	25b. REGISTRAR'S SIGNATURE John D. Anderson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove contents of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

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CHARLIE

LEE

ROBINSON

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

37 REG. NO. 36710

1. DECEASED NAME (TYPE OR PRINT) JUANITA M ROOKS			2a. DATE OF DEATH MONTH DAY YEAR 12 02 87		2b. HOUR 11 30A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 03 06 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKLAHOMA	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY U S Gov't
13a. STATE Maryland		13b. COUNTY Prince Geo	13c. CITY OR TOWN LANDOVER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel A Mitchell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Ann Rush			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-03-6692		17. INFORMANT Gladys M Rowles	
				ADDRESS 10 Whist Place Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 10 DAYS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

19a. DATE OF OPERATION OCT. 13, 1987	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (LT) KNEE INSTABILITY	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-12, 1987 to 12-2, 1987, that (I) (we) lost saw the deceased alive on 11-30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Samuel Alleyne</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-3-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL ALLEYNE, M.D.		22e. ADDRESS PRINCE GEO. HOSPITAL CTR., CHEVERLY, MD. 20785	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4Dec1987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		25. DATE REC'D BY REGISTRAR DEC 7 1987	
ADDRESS Funeral Home		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36711

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kevin T. Rudder										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12-13-19 87		2b. HOUR M 12:00 noon	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-30-1954 33 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-13 19 87		7d. HOUR M 12:00 noon			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD			
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical		12b. KIND OF BUSINESS OR INDUSTRY Electrical			
13a. STATE Md.													
13b. COUNTY AA Co.				13c. CITY OR TOWN Edgewater				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS 3720 3rd. Ave.				13f. STREET ADDRESS 21037									
14. FATHER'S NAME FIRST MIDDLE LAST Martin Rudder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Marie Sacavage									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-62-6892				17. INFORMANT ADDRESS Elizabeth M. Rudder Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Combined Drug Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) subject used drugs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE Mario F. Golle, Jr.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12-14-87					
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY Woodfield Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Galesville AA Co. Md.					
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				ADDRESS Annapolis Md.				25. DATE RECORDED DEC 18 1987					
25b. REGISTRAR'S SIGNATURE													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

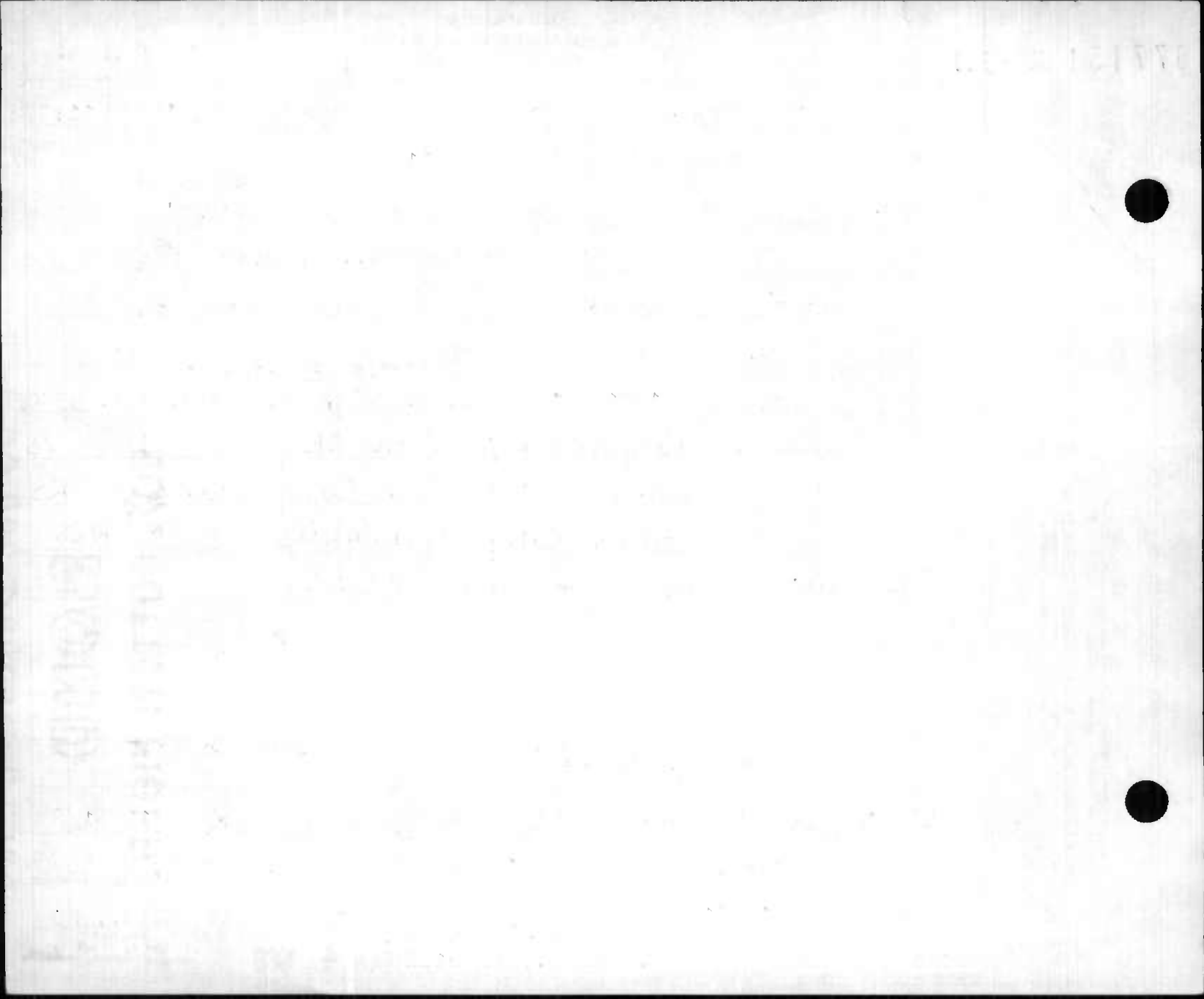
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH			3. HOUR			
Jack Connor Ryan			December 30, 1987		11:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR	
Male		Caucasian		03 MONTH 04 DAY 11 YEAR		76 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Tenn.		USA				Prince George's County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel-Beltsville Hosp.				Engineer		Tool & Die	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Howard		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20707 9330 Gorman Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John C. Ryan			Eloise Metz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO		N/A		4670-3 Lakeside Club Blvd Eloise R. Toll, Ft. Myers, Fla. 33905					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC Restrictive Lung Disease</u> YEARS DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANKYLOSING Spondylitis</u> YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes. Transitional Cancer Bladder</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>74</u> to <u>December</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>December</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		22c. DATE SIGNED			
<u>Andrew Marks</u> MD						12/31/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Andrew Marks, M.D.				9105 All Saints Rd. Laurel, MD 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation		12/31/87		Security Process		Catonsville Balto., MD			
24. FUNERAL DIRECTOR				24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Cremation Society of Md. Balto., MD 21228				299 Frederick Rd.		JAN 4 1988		<u>John E. ...</u>	

MEDICAL CERTIFICATION



074315 DEC 1-887

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 30713

1. DECEASED NAME (TYPE OR PRINT) PALMA Carmella SAITTA.			2a. DATE OF DEATH MONTH DAY YEAR 12-5-1987			2b. HOUR 5-15 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 07 24		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD				
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS Hosp of Pr. G.C.			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Ret. Manager	12b. KIND OF BUSINESS OR INDUSTRY Garvins			
13a. STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5711 Ellerbe Street 20706				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Russo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Helen Pirello						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 184-12-0701 A		17. INFORMANT ADDRESS James M. Saitta - son - (same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Cerebral Infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Hypertensive Heart Disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (1) Advanced Diabetes mellitus (2) Renal failure (3) Sepsis								
19a. DATE OF OPERATION 11-18-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prolonged Endotracheal Intubation		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 12/5/87 to 12/5/87 , that (I) (we) last saw the deceased alive on 12/5/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE S. R. Ledapi				DEGREE M.D.		22c. DATE SIGNED 12-5-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHRINIVAS R. UDAPATI, MD.				22e. ADDRESS 6005 Landover Rd. Cheverly MD 20785				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12-8-1987		23c. NAME OF CEMETERY OR CREMATORY Md. National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Pr. Georges Md.		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spr. Md.				25a. DATE REC'D. BY REGISTRAR DEC-7-1987		25b. REGISTRAR'S SIGNATURE John Anderson-Rudick		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36714

1- STATE REGISTRAR		2- DECEASED NAME (TYPE OR PRINT)		3- FIRST MIDDLE LAST		4- DATE KNOWN OF DEATH		5- MONTH DAY YEAR		6- HOUR	
Alston		C.		Sandy		12-15-87		12-15-87		5:15A	
7- SEX	8- RACE	9- DATE OF BIRTH		10- AGE (IN YEARS)		11- IF UNDER 1 YR.		12- IF UNDER 24 HRS.		13- DATE PRONOUNCED DEAD	
Male	White	6 21 1921		66 YRS.		MONTHS DAYS		HOURS MIN.		12-15-87 19	
14- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		15- CITIZEN OF WHAT COUNTRY?		16- MARRIED		17- NEVER MARRIED		18- BALTIMORE CITY OR COUNTY OF DEATH		19- DATE OF DEATH	
Virginia		USA		WIDOWED		DIVORCED		Prince George's County MD.		12-15-87	
20- CITY OR TOWN OF DEATH		21- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		22- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		23- KIND OF BUSINESS OR INDUSTRY		24- DATE OF DEATH		25- HOUR	
Laurel		Greater Laurel Beltsville Hospital		Craftsman		Wood (Ret)		12-15-87		5:15A	
26- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		27- STATE		28- COUNTY		29- CITY OR TOWN		30- INSIDE CITY LIMITS?		31- STREET ADDRESS	
Md.		Howard		Laurel		YES		NO		10520 Scaggsville Rd. 20707	
32- FATHER'S NAME		33- MOTHER'S MAIDEN NAME		34- ADDRESS		35- DATE OF DEATH		36- HOUR		37- MIN.	
Walter C. Sandy		Ellen Windgate		same as 13c		12-15-87		12-15-87		5:15A	
38- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		39- SOCIAL SECURITY NO.		40- INFORMANT		41- ADDRESS		42- DATE OF DEATH		43- HOUR	
n/a		213-20-8509		Alma Sandy		same as 13c		12-15-87		5:15A	
44- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Head injuries											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Chronic Alcoholism											
45- DATE OF OPERATION		46- CONDITION FOR WHICH OPERATION WAS PERFORMED?		47- AUTOPSY?		48- YES		49- NO		50- DATE OF DEATH	
12-14-87		Subject fell		YES		NO		12-15-87		5:15A	
51- EXTERNAL CAUSE WAS UNDERLYING		52- TIME OF INJURY		53- HOW INJURY OCCURRED		54- PLACE OF INJURY		55- LOCATION		56- DATE OF DEATH	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		CITY OR TOWN		COUNTY		STATE	
12-14-87		Subject fell		12-14-87		unknown		UNKNOWN		MD	
57- INJURY OCCURRED WHILE AT WORK		58- DATE OF INJURY		59- LOCATION		60- CITY OR TOWN		61- COUNTY		62- STATE	
NOT WHILE AT WORK		12-14-87		unknown		UNKNOWN		UNKNOWN		MD	
63- I certify that I have charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from											
Natural causes, Accident, Suicide, Homicide, Undetermined manner											
64- ACTUAL SIGNATURE											
Charles P. Kokes, M.D.											
65- TITLE (SPECIFY) Assistant MEDICAL EXAMINER											
66- DATE SIGNED 12-15-87											
67- EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.											
68- ADDRESS 111 Penn Street, Baltimore, MD 21201											
69- BURIAL, CREMATION, REMOVAL (SPECIFY)		70- DATE		71- NAME OF CEMETERY OR CREMATORY		72- LOCATION		73- COUNTY		74- STATE	
Burial		12/18/87		Meadowridge Cem.		Jessup		Howard		Md.	
75- FUNERAL DIRECTOR 7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707											
76- DATE REC'D BY REGISTRAR 21 1987											
77- REGISTRAR'S SIGNATURE											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO. 715	
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	7b. HOUR
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry W. Sapper										MONTH DAY YEAR 12-21 1987	M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1937	6 AGE IN YEARS (LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD	7d. HOUR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctor's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Eng.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4130 Crosswick Turn/ 20715			
14. FATHER'S NAME FIRST MIDDLE LAST Harrell F. Sapper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche I. Wilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1960		17. INFORMANT ADDRESS Dorothy F. Sapper, Same as # 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Asphyxia											
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of gastric content											
DUE TO, OR AS A CONSEQUENCE OF (c) Tracheal bronchitis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Obesity, Arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:30 P.M. 12-21 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Aspiration of gastric content while coughing							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION CITY OR TOWN COUNTY STATE 4130 Crosswick Turn, Bowie, Prince Geo. MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 12-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A., Maryland					
24. FUNERAL DIRECTOR NAME Beall Funeral Home				16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36710

1. DECEASED NAME (TYPE OR PRINT) CLARENCE HENRY SARTAIN JR		2a. DATE OF DEATH MONTH DAY YEAR 12 10 87		2b. HOUR 5:30 AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 21, 1916		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery str.
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Henry Sartain, Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW-II 578-05-3323		17. INFORMANT ADDRESS Helen N. Sartain -same as #13-	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CORONARY ARTERY DISEASE**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PERIPHERAL VASCULAR DISEASE**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 11 19 87 , to 12-10 19 87 , that (I) (we) last saw the deceased alive on 12-9 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE RAJ. SANTANI		DEGREE MD/FACC ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-10-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ. SANTANI MD		22e. ADDRESS 9131 PISCATAWAY ROAD CLINTON MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/14/87	23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Pr Geo., Md.
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS P.O. Box 156 Waldorf, Md 20601	25a. DATE REC'D. BY REGISTRAR DEC 14 1987
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This release (remove certificate) page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

075844 DEC 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36717

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilda Louise Satterfield			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1987		2b. HOUR 7:00 A.M.		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4 9 23		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Ft. Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2 Hickory St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Branch Chief		12b. KIND OF BUSINESS OR INDUSTRY Census Bureau	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Pr. George		13d. CITY OR TOWN Ft. Washington		13e. STREET ADDRESS 2 Hickory St. 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Edmund Overby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Irene Dalton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-28-7758	
17. INFORMANT ADDRESS Patricia A. Burton		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>x</u> Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) <u>x</u> Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 3 months		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 9/22/1987 to 12/17/1987, that (I) (we) last saw the deceased alive on 11/10/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE Victor M. Priego, M.D.	
22c. DATE SIGNED 12-17-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor M. Priego, M.D.		22e. ADDRESS 1160 Varnum St., N.E. #114 Washington, DC 20017		22f. DATE SIGNED 12-17-87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.	
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H.		25a. DATE REC'D. BY REGISTRAR DEC 21 1987		25b. REGISTRAR'S SIGNATURE Julia...		25c. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 35713
REG. NO.FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carrie Gray Saville			2a. DATE OF DEATH MONTH DAY YEAR 12-10-87			2b. HOUR 2:00 P M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR 12 09 1894		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Largo			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Largo Manor Nursing Home			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			13. STREET ADDRESS / ZIP CODE 6606 West Forest Road #202 20785		
13a. STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Landover		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Gray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Spaid			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. N/A			17. INFORMANT (Daughter) Dorothea S. Anderson			ADDRESS Same as Line #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <i>Schitz of age + pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebrovascular atherosclerosis + atrophy</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <i>1985</i> , to _____, 19 <i>12-3-87</i> , that (I) (we) last saw the deceased alive on _____, 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>James W. Harding MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/10/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Harding, M.D.						22e. ADDRESS 7525 Greenway Ctr. Dr. #316 Greenbelt, Md. 20770		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/14/87			23c. NAME OF CEMETERY OR CREMATORY George Washington		
23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland			24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, P.A.			25a. DATE REC'D. BY REGISTRAR DEC 17 1987		
25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "yes" above, injury, or other traumatic event, the medical examiner must be notified.

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NOTICE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36719

1- STATE REGISTRAR		FOR DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTIMATED DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR	
		Robert Allen Schmidt								12-3-87		12-3-87		12-3-87		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		8. MARRIED		9. NEVER MARRIED		10. DIVORCED	
Male		White		7-4-25		62		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. DIVORCED		11. BALTIMORE CITY OR COUNTY OF DEATH							
Pittsburg, PA.		U.S.A.								Prince George's						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Capitol Heights		735 Mentor Avenue		Boiler Engineer		DC Schools											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		P. G.		Capitol Heights		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		735 Mentor Avenue								20743	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Charles		Kathryn		Yes		1943-1945		Virginia Schmidt		Same as 13 A-E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF											
				Arterio-sclerotic cardiac vascular disease													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Augusto P. Rodriguez		Deputy		12-3-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12/05/87		Cedar Hill Cemetery		Suitland Prince George's Md.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Lee Funeral Home, Inc.		DEC - 9 1987		Julia Davidson-Randall													
6633 Old Alexander Ferry Rd. Clinton, Md 20735																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. ATTACH PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT - PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17

(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36721

1. DECEASED NAME (TYPE OR PRINT) ELIZA BETH SCHMITT			2a. DATE OF DEATH MONTH DAY YEAR 12 24 87		2b. HOUR 545 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-28-1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Beltsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4419 Romion St. #102		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Operator		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Beltsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Hale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Kaczorowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 136-20-3054		17. INFORMANT ADDRESS Karl Schmitt same as above #13c.	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ORGANIC BRAIN SYNDROME					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 12/21 19 87 , to 12/24 19 87 , that (b) (we) lost above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregory A. Compton MD DEGREE				22c. DATE SIGNED 12/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A COMPTON				22e. ADDRESS 8317 Cherry Lane Laurel MD 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-1987		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
23d. LOCATION CITY OR TOWN Trenton		23e. COUNTY Mercer		23f. STATE New Jersey	
24. FUNERAL DIRECTOR Donald V. Borgwardt		24b. ADDRESS 4400 Powder Mill Rd. Beltsville, Maryland		25. DATE REC'D BY REGISTRAR DEC 30 1987	

077007 JAN 15 1988

Item #1 G 638 4/5/88

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC-6 1222

1. DECEASED NAME (TYPE OR PRINT) Eldrae Eldridge Isaac Scott		3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 2 1946		6. AGE (IN YEARS) (LAST BIRTHDAY) 41 YRS.		7c. DATE Pronounced DEAD MONTH DAY YEAR 12 25 87		2d. HOUR 4AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD							
10. CITY OR TOWN OF DEATH Largo		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16405 Old Central Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY A.A.		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16401 Central Ave. 20713			
14. FATHER'S NAME FIRST MIDDLE LAST REGINALD SCOTT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA MEDLEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-46-0767		17. INFORMANT Upper Marlboro, Md. 20772 GLADYS BROWN 8909 South Cherry Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries & smoke & soot inhalation DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 25 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) House fire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 16405 Old Central Avenue, Largo, P.G.CO., MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Hand F. Golle, Jr.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12/25/87					
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr.				ADDRESS 111 Penn St.				Balto., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-39		23c. NAME OF CEMETERY OR CREMATORY OUR LADY OF SORROW CEME.				23d. LOCATION CITY OR TOWN COUNTY STATE Owensville A.A. Maryland			
24. FUNERAL DIRECTOR NAME William Reese & Sons Mortuary, PA				25a. DATE REC'D. BY REGISTRAR DEC 30 1987				25b. REGISTRAR'S SIGNATURE Julia Swickard					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

7 2 5

1- STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Russell

Finley

Scott

7a. DATE KNOWN
OF
DEATH ESTI-
MATED ☒MONTH DAY YEAR HOUR
12/2 19 87 M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

Aug 23, 1925 62 YRS

6. AGE (IN YEARS
LAST BIRTHDAY)

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN.

IF UNDER 24 HRS.

7c. DATE
PRONOUNCED
DEADMONTH DAY YEAR HOUR
12/2 19 87 P. 9:50 M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County MD

10. CITY OR TOWN OF DEATH

Mt. Rainier

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

3206 Chillum Road, #102

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Postman

12b. KIND OF BUSINESS
OR INDUSTRY

Govt.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince George's

13c. CITY OR TOWN

Mt. Rainier

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3206 Chillum Road, #102

14. FATHER'S NAME

Othello M. Scott

15. MOTHER'S MAIDEN NAME

Rebecca Stith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) ☒ IF YES, GIVE WAR OR DATES

No

16b. SOCIAL SECURITY NO.

225 34 8591

17. INFORMANT

Russell F. Scott Jr. Wash, DC 20002

ADDRESS 4716 - 6 PI, NE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute and chronic alcoholism.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

None

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED 12/3/87

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS 1919 Seminary Road
Silver Spring, Montgomery County, MD23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/7/87

23c. NAME OF CEMETERY OR CREMATORY

Wood Lawn

23d. LOCATION
(CITY OR TOWN)

Richmond, VA

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

M. Dudley & Sons F. Home
3200 Rhode Island Ave Mt. Rainier, Md

25a. DATE REC'D. BY REGISTRAR

DEC - 8 1987

25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DEC-8-1937

078343 JAN 17 1988

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36724

1. DECEASED NAME (TYPE OR PRINT) JOHN T. SCRIBNER			2a. DATE OF DEATH MONTH DAY YEAR 11 16 87		2b. HOUR 10:15 AM
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 25 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming
13a. STATE Md.		13b. COUNTY CLINTON	13c. CITY OR TOWN Upper Marlboro	13d. STREET ADDRESS / ZIP CODE 15119 Peerless Avenue 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Scribner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 12 73164		17. INFORMANT ADDRESS 15119 Peerless Ave Josh Scribner (brother) Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-Renal Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to, or as a consequence of (c) Jaundice, Cirrhosis Hepatitis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 13 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 11-16-87	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) CLINTON		21f. LOCATION CITY OR TOWN COUNTY STATE CLINTON MARYLAND	
22a. I certify that (I) (this hospital) attended the deceased from 11-16-87 to 11-16-87 , that (I) (we) lost saw the deceased alive on 11-16-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Abul Hasan U Ansari		DEGREE MD		22c. DATE SIGNED 11/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI		22e. ADDRESS 8926 Woodland Rd. #101 Clinton Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/21/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY	
23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS ROLLINS FUNERAL HOME, INC. 4339 HUNT PL. NE.			
25a. DATE REC'D. BY REGISTRAR JAN 12 1988		25b. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These permits remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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01 12 1939

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Handwritten notes and calculations, including a table with columns for numbers and text. The text is mostly illegible due to fading and bleed-through.